State of Hawaii
Department of Health
Family Health Services Division
Maternal and Child Health Branch/Healthy Start Program

Request for Proposals

RFP No. HTH 550-3

RFP Title:
Primary Prevention of Child Abuse and Neglect (Child Maltreatment)

Sub Category:
Home Visiting

October 12, 2004

Note: If this RFP was downloaded from the State Procurement Office RFP Website each applicant must provide contact information to the RFP contact person for this RFP to be notified of any changes. For your convenience, an RFP Interest form may be downloaded to your computer, completed and e-mailed or mailed to the RFP contact person. The State shall not be responsible for any missing addenda, attachments or other information regarding the RFP if a proposal is submitted from an incomplete RFP.

LINDA LINGLE
GOVERNOR OF HAWAII

CHIYOME L. FUKINO, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
FAMILY HEALTH SERVICES DIVISION
MATERNAL AND CHILD HEALTH BRANCH
741-A SUNSET AVENUE
HONOLULU, HAWAII 96816

October 12, 2004

REQUEST FOR PROPOSALS

Primary Prevention of Child Abuse and Neglect
Home Visiting
RFP No. DOH 550-3

The Department of Health, Family Health Services Division, Maternal and Child Health Branch, Family and Community Support Section (FCSS) is requesting proposals from qualified applicants to provide a variety of family support intervention services for prenatal women and families with infants and children zero to five (0-5) years of age, with emphasis on children under three (3) years of age, who are at-risk for child maltreatment. This includes: 1) community based, culturally sensitive home visiting, and 2) a variety of family support intervention services. The contract term will be from July 1, 2005 through June 30, 2009. Multiple contracts will be awarded under this request for proposals.

Proposals shall be mailed and postmarked by the United State Postal Service on or before January 14, 2005, or hand delivered no later than 4:30 p.m., Hawaii Standard Time (HST), on January 14, 2005, at the drop-off sites designated on the Proposal Mail-in and Delivery Information Sheet. Proposals postmarked or hand delivered after the submittal deadline shall be considered late and rejected. There are no exceptions to this requirement.

The Family Health Services Division will conduct an orientation on **October 29, 2004 from 1:00 p.m. to 3:30 p.m. HST, at the Ala Wai Golf Course Clubhouse Multi-Purpose Recreational Facility – 2nd floor, 404 Kapahulu Avenue, Honolulu, Hawaii.** All prospective applicants are encouraged to attend the orientation.

The deadline for submission of written questions is 4:30 p.m., HST, on November 12, 2005. All written questions will receive a written response from the State on or about November 30, 2004.

Inquiries regarding this RFP should be directed to the RFP contact person, Mark Yabui at 741-A Sunset Avenue, Honolulu, Hawaii 96816, telephone: (808) 733-4181, fax: (808) 733-9078, e-mail: mark.yabui@fhsd.health.state.hi.us

PROPOSAL MAIL-IN AND DELIVERY INFORMATION SHEET

NUMBER OF COPIES TO BE SUBMITTED: Original + 3 Copies

ALL MAIL-INS MUST BE POSTMARKED BY UNITED STATES POSTAL SERVICE (USPS) NO LATER THAN January 14, 2005

All Mail-ins

Department of Health
Administrative Services Office
P.O. Box 3378
Honolulu, Hawaii 96801-3378

DOH RFP COORDINATOR

Valerie Ako
For further info. or inquiries
Phone: 586-4550
Fax: 586-4649

ALL HAND DELIVERIES WILL BE ACCEPTED AT THE FOLLOWING SITES UNTIL **4:30 P.M., Hawaii Standard Time (HST) January 14, 2004.**

Drop-off Sites

Oahu:
Department of Health
Administrative Services Office Room 310,
Kina'u Hale
1250 Punchbowl Street
Honolulu, Hawaii

Maui:
Department of Health
Maui District Health Office
State Office Building, 3rd Floor
54 High Street
Attn: DOH Admin. Svcs. Office

East Hawaii:
Department of Health
Hawaii District Health Office
State Office Building, Room 105
75 Aupuni Street
Attn: DOH Admin. Svcs. Office

Kauai:
Department of Health
Kauai District Health Office
Lihue Health Center
3040 Umi Street
Lihue, Kauai
Attn: DOH Admin. Svcs. Office

West Hawaii:
Department of Health
Kealakekua Business Plaza
81-980 Haleki'i Street
Kealakekua, Hawaii
Attn: DOH Admin. Svcs. Office

BE ADVISED: All mail-ins postmarked by USPS after **January 14, 2005**, will be rejected.

Hand deliveries will **not** be accepted after **4:30 p.m., HST, January 14, 2005.**

Deliveries by private mail services such as FEDEX shall be considered hand deliveries and will not be accepted if received after **4:30 p.m., HST, January 14, 2005.**

RFP Table of Contents

Section 1 - Administrative Overview

Section 2 - Service Specifications

Section 3 - Proposal Application Instructions

Section 4 – Proposal Evaluation

Section 5 – Attachments

Section 1

Administrative Overview

Section 1
Administrative Overview

Applicants are encouraged to read each section of the RFP thoroughly. While sections such as the administrative overview may appear similar among RFPs, state purchasing agencies may add additional information as applicable. It is the responsibility of the applicant to understand the requirements of *each* RFP.

I. Authority

This RFP is issued under the provisions of the Hawaii Revised Statutes (HRS), Chapter 103F and its administrative rules. All prospective applicants are charged with presumptive knowledge of all requirements of the cited authorities. Submission of a valid executed proposal by any prospective applicant shall constitute admission of such knowledge on the part of such prospective applicant.

II. RFP Organization

This RFP is organized into five sections:

Section 1, Administrative Overview--Provides applicants with an overview of the procurement process.

Section 2, Service Specifications--Provides applicants with a general description of the tasks to be performed, delineates applicant responsibilities, and defines deliverables (as applicable).

Section 3, Proposal Application Instructions--Describes the required format and content for the proposal application.

Section 4, Proposal Evaluation--Describes how proposals will be evaluated by the state purchasing agency.

Section 5, Attachments --Provides applicants with information and forms necessary to complete the application.

III. Contracting Office

The Contracting Office is responsible for overseeing the contract(s) resulting from this RFP, including system operations, fiscal agent operations, and monitoring and assessing provider performance. The Contracting Office is:

Maternal and Child Health Branch
Family and Community Support Section
Department of Health, State of Hawaii
741-A Sunset Avenue
Honolulu, Hawaii 96816
Phone: (808) 733-4181 Fax: (808) 733-9078

IV. Procurement Timetable

Note that the procurement timetable represents the State's best estimated schedule. Contract start dates may be subject to the issuance of a notice to proceed.

Activity	Scheduled Date
Public notice announcing RFP	Oct. 12, 2004
Distribution of RFP	Oct. 12, 2004
RFP orientation session	Oct. 29, 2004
Closing date for submission of written questions for written responses	Nov. 12, 2004
State purchasing agency's response to applicants' written questions	Nov. 30, 2004
Discussions with applicant prior to proposal submittal deadline (optional)	Nov-Dec 2004
Proposal submittal deadline	Jan. 14, 2005
Discussions with applicant after proposal submittal deadline (optional)	Jan. 18 – Feb. 15, 2005
Final revised proposals (optional)	Feb. 25, 2005
Proposal evaluation period	Late Jan-Mar 2005
Provider selection	April 2005
Notice of statement of findings and decision	April 2005
Contract start date	July 1, 2005

V. Orientation

An orientation for applicants in reference to the request for proposals will be held as follows:

Date:	**October 29, 2004**	**Time:**	**1:00 p.m. to 3:30 p.m.**
Location:	**Ala Wai Golf Course Clubhouse. Multi-Purpose Recreational Facility – 2nd floor, 404 Kapahulu Avenue, Honolulu, Hawaii**		

Applicants are encouraged to submit written questions prior to the orientation. Impromptu questions will be permitted at the orientation and spontaneous answers provided at the state purchasing agency's discretion. However, answers provided at the orientation are only intended as general direction and may not represent the state purchasing agency's position. Formal official responses will be provided in writing. To ensure a written response, any oral questions should be submitted in writing following the close of the orientation, but no later than the submittal deadline for written questions indicated in the next paragraph (VI. Submission of Questions).

VI. Submission of Questions

Applicants may submit questions to the RFP Contact Person identified in Section 2 of this RFP. All written questions will receive a written response from the state purchasing agency.

Deadline for submission of written questions:

Date: **November 12, 2004** **Time:** 4:30 p.m. HST

State agency responses to applicant written questions will be provided by**:**

Date: **November 30, 2004**

VII. Submission of Proposals

A. **Forms/Formats -** Forms, with the exception of program specific requirements, may be found on the State Procurement Office website at: www.spo.hawaii.gov, click *Procurement of Health and Human Services* and *For Private Providers.* Refer to the Proposal Application Checklist for the location of program specific forms.

1. **Proposal Application Identification (Form SPO-H-200) -** Provides identification of the proposal.

2. **Proposal Application Checklist –** Provides applicants with information on where to obtain the required forms; information on program specific requirements; which forms are required and the order in which all components should be assembled and submitted to the state purchasing agency.

3. **Table of Contents -** A sample table of contents for proposals is located in Section 5, Attachments. This is a sample and meant as a guide. The table of contents may vary depending on the RFP.

4. **Proposal Application (Form SPO-H-200A) -** Applicant shall submit comprehensive narratives that addresses all of the issues contained in the Proposal Application Instructions, including a cost proposal/budget if required. (Refer to Section 3 of this RFP.**)**

5. **Registration Form (SPO-H-100A) –** If applicant is not registered with the State Procurement Office (business status), this form must be submitted with the application. If applicant is unsure as to their registration status, they may check the State Procurement Office website at: http://www.spo.hawaii.gov, click *Procurement of Health and Human Services*, and *For Private Providers* and *Provider Lists…The List of Registered Private Providers for Use with*

the Competitive Method of Procurement or call the State Procurement Office at (808) 587-4706.

6. **Tax Clearance –** A certified copy of a current valid tax clearance certificate issued by the State of Hawaii, Department of Taxation (DOTAX) and the Internal Revenue Service (IRS) will be required either at the time of proposal submittal or upon notice of award at the discretion of the purchasing agency.

   Refer to Section 4, item III.A.1, Administrative Requirements, and the Proposal Application Checklist to see if the tax clearance is required at time of proposal submittal. The tax clearance application may be obtained from the Department of Taxation website at www.hawaii.gov/tax/tax.html.

B. Program Specific Requirements - Additional program specific requirements are included in Sections 2 and/or 3, Service Specifications and the Proposal Application Instructions, as applicable. If Federal and/or State certifications are required, they are listed on the Proposal Application Checklist.

C. Multiple or Alternate Proposals - Multiple or alternate proposals shall not be accepted unless specifically provided for in Section 2 of this RFP. In the event alternate proposals are not accepted and an applicant submits alternate proposals, but clearly indicates a primary proposal, it shall be considered for award as though it were the only proposal submitted by the applicant.

D. Proposal Submittal - Proposals must be postmarked by USPS or hand delivered by the date and time designated on the Proposal Mail-In and Delivery Information Sheet attached to this RFP. Any proposal post-marked or received after the designated date and time shall be rejected. Note that postmarks must be by United States Postal Service or they will be considered hand-delivered and shall be rejected if late. The number of copies required is located on the Proposal Mail-In and Delivery Information Sheet.

Submission of proposals by applicants through telefacsimilie, electronic mail and/or computer diskette is not permitted by the state purchasing agency.

E. Wages and Labor Law Compliance - Before a provider enters into a service contract in excess of $25,000, the provider shall certify that it complies with section 103-55, HRS, Wages, hours, and working conditions of employees of contractors performing services. Section

103-55, HRS may be obtained form the Hawaii State Legislature website at http://www.capitol.hawaii.gov/. Or go directly to: http://www.capitol.hawaii.gov/hrscurrent/Vol02_Ch0046-0115/HRS0103/HRS_0103-0055.htm

F. Confidential Information – If an applicant believes any portion of a proposal contains information that should be withheld as confidential, the applicant shall request in writing nondisclosure of designated proprietary data to be confidential and provide justification to support confidentiality. Such data shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal.

Note that price is not considered confidential and will not be withheld.

VIII. Discussions with Applicants

A. Prior to Submittal Deadline. Discussions may be conducted with potential applicants to promote understanding of the purchasing agency's requirements.

B. After Proposal Submittal Deadline - Discussions may be conducted with applicants whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance section 3-143-403, HAR.

IX. Opening of Proposals

Upon receipt of proposal by a state purchasing agency at a designated location, proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped, and when possible, time-stamped. All documents so received shall be held in a secure place by the state purchasing agency and not examined for evaluation purposes until the submittal deadline.

Procurement files shall be open to public inspection after a contract has been awarded and executed by all parties.

X. Additional Materials and Documentation

Upon request from the state purchasing agency, each applicant shall submit any additional materials and documentation reasonably required by the state purchasing agency in its evaluation of the proposals.

XI. RFP Amendments

The State reserves the right to amend this RFP at any time prior to the closing date for the final revised proposals.

XII. Final Revised Proposals

The applicant's final revised proposal, *as applicable* to this RFP, must be postmarked or hand delivered by the date and time specified by the state purchasing agency. Any final revised proposal post-marked or received after the designated date and time shall be rejected. If a final revised proposal is not submitted, the previous submittal shall be construed as their best and final offer/proposal. *The applicant shall submit* ***only*** *the section(s) of the proposal that are amended, along with the Proposal Application Identification Form (SPO-H-200).* After final revised proposals are received, final evaluations will be conducted for an award.

XIII. Cancellation of Request for Proposal

The request for proposal may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State.

XIV. Costs for Proposal Preparation

Any costs incurred by applicants in preparing or submitting a proposal are the applicants' sole responsibility.

XV. Provider Participation in Planning

Provider participation in a state purchasing agency's efforts to plan for or to purchase health and human services prior to the state purchasing agency's release of a request for proposals, including the sharing of information on community needs, best practices, and providers' resources, shall not disqualify providers from submitting proposals if conducted in accordance with sections 3-142-202, 3-142-203 and 3-143-618 of the Hawaii Administrative Rules for Chapter 103F, HRS.

XVI. Rejection of Proposals

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the problems involved and comply with the service specifications. Any proposal offering any other set of terms and conditions contradictory to those included in this RFP may be rejected without further notice.

A proposal may be automatically rejected for any one or more of the following reasons: (Relevant sections of the Hawaii Administrative Rules for Chapter 103F, HRS, are parenthesized)

(1) Rejection for failure to cooperate or deal in good faith. (Section 3-141-201, HAR)

(2) Rejection for inadequate accounting system. (Section 3-141-202, HAR)

(3) Late proposals (Section 3-143-603, HAR)

(4) Inadequate response to request for proposals (Section 3-143-609, HAR)

(5) Proposal not responsive (Section 3-143-610 (1), HAR)

(6) Applicant not responsible (Section 3-143-610 (2), HAR)

XVII. Notice of Award

A statement of findings and decision shall be provided to all applicants by mail upon completion of the evaluation of competitive purchase of service proposals.

Any agreement arising out of this solicitation is subject to the approval of the Department of the Attorney General as to form, and to all further approvals, including the approval of the Governor, required by statute, regulation, rule, order or other directive.

No work is to be undertaken by the awardee prior to the contract commencement date. The State of Hawaii is not liable for any costs incurred prior to the official starting date.

XVIII. Protests

Any applicant may file a protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the SPO website (see the Proposal Application Checklist in Section 5 of this RFP. Only the following matters may be protested:

(1) A state purchasing agency's failure to follow procedures established by Chapter 103F of the Hawaii Revised Statutes;

(2) A state purchasing agency's failure to follow any rule established by Chapter 103F of the Hawaii Revised Statutes; and

(3) A state purchasing agency's failure to follow any procedure, requirement, or evaluation criterion in a request for proposals issued by the state purchasing agency.

The Notice of Protest shall be mailed by USPS or hand delivered to the head of the state purchasing agency conducting the protested procurement and the procurement officer who is conducting the procurement (as indicated below) within five working days of the postmark of the Notice of Findings and Decision sent to the protestor. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of actual receipt by the state purchasing agency.

Head of State Purchasing Agency	**Procurement Officer**
Name: Chiyome Leina'ala Fukino, M.D.	Name: Ann H. Kinningham
Title: Director of Health	Title: Chief, Administrative Services Office
Mailing Address: P.O. Box 3378, Honolulu, HI 96801	Mailing Address: P.O. 3378, Honolulu, HI 96801
Business Address: 1250 Punchbowl St., Honolulu, HI	Business Address: 1250 Punchbowl St., Honolulu, HI

XIX. Availability of Funds

The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to Chapter 37, HRS, and subject to the availability of State and/or Federal funds.

XX. Monitoring and Evaluation

The criteria by which the performance of the contract will be monitored and evaluated are:

(1) Performance/Outcome Measures

(2) Output Measures

(3) Quality of Care/Quality of Services

(4) Financial Management

(5) Administrative Requirements

XXI. General and Special Conditions of Contract

The general conditions that will be imposed contractually are on the SPO website. (See Section 5, Proposal Application Checklist for the address). Special conditions may also be imposed contractually by the state purchasing agency, as deemed necessary.

XXII. Cost Principles

In order to promote uniform purchasing practices among state purchasing agencies procuring health and human services under Chapter 103F, HRS, state purchasing agencies will utilize standard cost principles outlined in Form SPO-H-201 which is available on the SPO website (see section 5, the Proposal Application Checklist). Nothing in this section shall be construed to create an exemption from any cost principle arising under federal law.

Section 2

Service Specifications

Section 2
Service Specifications

I. Introduction

A. Overview, purpose or need

Children identified as at-risk are born to parents whose circumstances and life experiences render them ill equipped to provide a nurturing home. These children are at increased risk for sub-optimal health, developmental delay and maltreatment. Research indicates this problem is a serious threat to the lives of children today and will have a tremendous impact on the lives of adults in the future. In Hawaii the incidence of confirmed child maltreatment increased by thirty-four percent (34%) from 2000-2003 (Department of Human Services' Annual Reports). The major precipitating factors of child maltreatment include an inability to cope with parenting problems and life stressors such as inadequacies in income and housing, substance use, mental health issues such as maternal depression, and family violence including intimate partner abuse. For such families, Healthy Start is a comprehensive, culturally sensitive and coordinated system of family strengthening support services focusing on prevention and early intervention within the natural context of the family. This is the state's response for meeting the needs of at-risk families.

Hawaii Healthy Start (HHS) is a comprehensive program with two key program components: Early Identification (EID) and Home Visiting (HV). The Hawaii Healthy Start program model **(See Attachment C)** delivers family centered services according to evidence-based practice to positively impact the malleable risk factors of each family. Family centered services occur in the natural environment to meet the multiple needs of at-risk families and utilize a team approach that includes guidance of the specialists including the Clinical Supervisor (CS), the Child Development Specialist (CDS), and the Clinical Specialist (CSp).

The Hawaii State Department of Health (HDOH), Family Health Services Division (FHSD), Maternal and Child Health Branch (MCHB), Family and Community Support Section (FCSS) is soliciting applications for the purposes of providing comprehensive home visitation services to at-risk families, both prenatal and postnatal, in the state of Hawaii determined eligible through a screening/assessment/referral process (the Early Identification process, or EID). Home visitation services must be based on the Hawaii Healthy Start program model including specialists services to address the needs of child development and family functioning.

B. Description of the goals of the service

The major goals of HOME VISITING are to:

1. Enhance family functioning by providing family centered services in their natural environment to reduce family stressors.

2. Promote positive child development focusing upon parent-child interaction and parents' knowledge and awareness of infant/toddler needs.

3. Promote and teach parents problem solving skills and awareness of community resources to attain their goals and become self sufficient.

4. Reduce the incidence of child maltreatment among at-risk families by addressing the malleable risk factors of the families.

The major activities of HOME VISITING are to:

1. Engage and retain at risk families referred to the home visiting program.

2. Utilize program model protocols, procedures, timelines, and tools to identify, assess, strategize, address, and monitor risk status of referred families. This involves building and maintaining trusting relationships while providing family-centered services in coordination with other appropriate agencies/staff.

3. Ensure that families at risk for child maltreatment receive appropriate medical and social services.

4. Provide specialist services in the areas of child development and family intervention.

C. Description of the target population to be served

Prenatal women and infants under the age of one (1) year who may continue up to five (5) years of age, providing the family has a subsequent target child under three (3) years of age identified as at-risk and receiving services.

See part II.B of this Section 2 of the RFP for related information about the planned secondary purchase.

D. Geographic coverage of service

Statewide

See part II.B of this Section 2 of the RFP for related information about the planned secondary purchase.

E. Probable funding amounts, source, and period of availability

For the contract terms:

State funds $9,142,075
Tobacco Settlement funds $4,747,667
Special funds $0

Based on availability of funding and a continuation of need. Additional funding may become available over the life of the contract, and the sources of funding may change.

See part II.B of this Section 2 of the RFP for related information about the planned secondary purchase.

II. General Requirements

A. Specific qualifications or requirements, including but not limited to licensure or accreditation

The applicant shall comply with the Chapter 103F, HRS Cost Principles for Purchases of Health and Human Services identified in SPO-H-201 (Effective 10/1//98), which can be found on the SPO website (See Section 5, POS Proposal Checklist, for the website address).

B. Secondary purchaser participation
(Refer to §3-143-608, HAR)

After-the-fact secondary purchases will be allowed.

Planned secondary purchases

The Department of Human Services is a planned secondary purchaser dependent upon the availability of funding. DHS may purchase Enhanced Healthy Start services on all islands to serve Child Welfare Service (CWS) clients and CWS Diversion service clients. The enhanced services include an RPN instead of a child development specialist and a clinical specialist who preferably is a Certified Substance Abuse Counselor (CSAC) or at least has experience in working with substance abusing families. These professionals may provide extended service to clients instead of limiting their services to 90 days of treatment readiness. Preferably the supervisor will have CSAC

certification if the clinical specialist does not. The paraprofessional Family Support Workers have reduced caseloads of 15-18 families in the Enhanced Healthy Start model instead of up to 25 families per worker. The anticipated amount of funding projected by DHS is $3,200,000 statewide with the following sections receiving approximately $400,000 depending upon the varying costs per section: one on Kauai, one on Maui covering Lanai, one on Molokai, and two on Hawaii. The funding for Oahu will be approximately $1,200,000 and will be distributed based on the primary purchaser's awardees and their geographic areas of coverage.

It is anticipated that the source of funds will be from the federal Temporary Assistance to Needy Families Program (TANF) under Title IVA of the Social Security Act. Additional funding may become available over the life of the contract, and the sources of funding may change. Funding for any given year, for any geographic area, or for any contract as a whole may increase up to 300% of the original amount without being considered a fundamental change according to section 3-149-303(d) of Hawaii Administrative Rules. Increases are subject to the availability of funds as well as acceptable program utilization, satisfactory performance, and need as determined by DHS.

C. Multiple or alternate proposals
(Refer to §3-143-605, HAR)

☐ Allowed ☒ Unallowed

D. Single or multiple contracts to be awarded
(Refer to §3-143-206, HAR)

☐ Single ☒ Multiple ☐ Single & Multiple

Criteria for multiple awards:

- Census tracts 1-12, (Portlock Road to Paalea Street)
- Census tracts 13-34 (Kaimuki to H-1 Punahou)
- Census tracts 35-43 (Kaahumanu School to Puowaina)
- Census tracts 44-65 (Pauoa to Upper Kalihi Valley)
- Census tracts 66-75 (Kahauiki to Red Hill (Navy) Housing)
- Census 77-82 (Lower Aiea to Waipio Peninsula)
- Census tracts 83-86 (Iroquois Point to Ko Olina-Campbell Industrial Park) Excluding Honokai Hale Subdivision.
- Census tracts 87-89 (Waipahu Park to Waipio Gentry)
- Census tracts 90-95, 99-100 (Wheeler-East Range to Beaver Road, Waialua-Mokuleia to Haleiwa-Kawailoa)
- Census tracts 96-98 (Nanakuli-Lualualei to Makaha Valley-Mauka) Including Honokai Hale Subdivision.

- Census tracts 101-102 (Waimea-Kahuku, Laie)
- Census tracts 103-108 (Kapunahala to Mokapu-East)
- Census tracts 109-113 (Puu Papaa to Waimanalo Beach-Homesteads)
- Island of Hawaii (West) - Census tracts 212 (tax key 9.1-9.2, 9.3 West of South Pt.)-218
- Island of Hawaii (East)– Census tracts 201-212 (tax key 9.4-9.6, 9.3 East of South Pt.), 219-221
- Island of Maui – Census tracts 301-315
- Island of Lanai – Census tracts 316
- Island of Molokai – Census tracts 317-318
- Island of Kauai – Census tracts 401-409

Applicant shall identify geographic areas by name of location and corresponding census tracts in Proposal.

Any Census tracts not chosen will be up for negotiation.

The secondary purchaser, DHS, will execute separate contracts with the primary purchaser's awardees.

E. Single or multi-term contracts to be awarded
(Refer to §3-149-302, HAR)

☐ Single term (≤ 2 yrs) ☒ Multi-term (> 2 yrs.)

Contract terms:

July 1, 2005 to June 30, 2009

For the islands of Kauai, Lanai, Maui and Molokai, each island will have one contract. For the island of Hawaii (East and West), two contracts will be awarded. On the island of Oahu, a minimum of three contracts will be awarded.

F. RFP contact person

The individual listed below is the sole point of contact from the date of release of this RFP until the selection of the successful provider or providers. Written questions should be submitted to the RFP contact person and received on or before the day and time specified in Section I, Item IV (Procurement Timetable) of this RFP.

Mark Yabui, Contract Specialist
Maternal and Child Health Branch
Family Health Services Division
741-A Sunset Avenue
Honolulu, Hawaii 96816
Phone: (808) 733-4181
Fax: (808) 733-9078

III. Scope of Work

The scope of work encompasses the following tasks and responsibilities:

A. Service Activities

(Minimum and/or mandatory tasks and responsibilities)

Select geographic areas by name of location and corresponding census tracts.

Comprehensive Home Visiting Services:
Applicant shall:

1. Utilize a variety of evidence-based interventions and strategies to reduce stressors that can interfere with family functioning and the parent-child relationship to reduce the likelihood of child maltreatment.

2. Specify interventions and strategies that include and emphasize engagement, retention, and creative outreach of eligible and referred at-risk families, including prenatal families.

3. Promote family resiliency by enhancing communication, socialization, decision-making, leadership, coping, and parenting skills.

4. Develop Individualized Family Service Plans (IFSP) with families as mandated by Public Law 105-17. All services shall be provided in close accordance with specific goals and objectives as delineated in the IFSP in conjunction with other related services.

5. Be aware and familiar with community resources for referrals, support, and continued utilization of services to ensure success in reducing risk factors/stressors and meeting family goals.

6. Engage and involve all family members, including fathers, in all services and activities.

7. Move families toward improved functionality according to the Hawaii Healthy Start Level Movement System [**See HHS Program Model – Attachment C]**.

8. Promote physical and mental wellness and behaviors of the child and family.

9. Disseminate family planning information and promote family planning so that every child is a wanted child.

10. Promote positive pregnancy outcomes by encouraging early and continuous prenatal care.

11. Support families in identifying and utilizing a medical home to ensure wellness and sick care.

12. Support families in identifying and utilizing a dental home to ensure dental health.

13. Promote healthy behaviors related to the health and safety of the child and family.

14. Monitor development of the child utilizing screening instruments specified and determined by the MCHB.

15. Promote positive child development, by focusing on a variety of parent child interaction activities. This shall include training on developmental issues and role modeling of developmentally appropriate intervention for both parents and staff.

16. Promote family resiliency, focusing upon a variety of family strengthening activities, including but not limited to substance use (including smoking), family violence (including intimate partner abuse), and mental health issues (including maternal depression), that also includes training on family support issues and role modeling coping strategies for both parents and staff.

17. Document status of referrals made to community agencies and programs for the child and family.

18. Conduct psycho-social assessments and case management activities, including but not limited to a care plan for families who are experiencing personal and/or emotional problems.

19. Describe the following specified roles and how each individually and collectively interface with the home visiting program as a whole. Included shall be descriptions of the scope of service, intervention strategies and their respective parameters, the role of this person in relation to the home visiting team and family, and how the specific specialist will integrate services into the IFSP, and any other description needed.

- Clinical Supervisor (CS)
- Child Development Specialist (CDS)
- Clinical Specialist (CSp)

20. Provide up to three (3) months of short-term interventions and strategies to work through the families' denial process and to motivate families to seek long term treatment and counseling in areas which may include substance use/abuse, family violence, and related mental health issues.

21. Provide services in coordination with other agencies and staff to ensure optimal outcomes for the best interest of the child and family.

22. Prioritize enrollment into the HHS program for families previously known to Baby S.A.F.E and other MCHB programs. Hawaii Healthy Start programs will refer to Baby S.A.F.E and other MCHB programs as appropriate.

See part II.B of this Section 2 of the RFP for related information about the planned secondary purchase.

B. Management Requirements (Minimum and/or mandatory requirements)

1. Personnel

Program Directors specifically charged with administration of the contract shall have direct and proven experience in child maltreatment prevention and/or intervention programs within the past five (5) years and possess management, communication, and organizational skills to ensure achievement of all contracted performance objectives and designate best practice standards and guidelines as part of the Hawaii Healthy Start Program Model.

A.) Clinical Supervisors shall possess the following qualifications:

1) Masters degree in health or human services; with a minimum of four (4) years experience in a child maltreatment prevention and/or intervention program of which two (2) years shall be in health and/or human services supervision/management, OR

2) A Bachelor degree in health or human services; with a minimum of five (5) years experience in a child maltreatment prevention and/or intervention program of which two (2) years shall be in health or human services supervision/management.

B) Clinical Specialist (CSp) shall possess the following qualifications:

1) Masters degree in Social Work, Clinical Psychology, Nursing or Counseling; with a minimum of four (4) years experience in a child maltreatment prevention and/or intervention program

   Licensed social workers and/or Certified Substance Abuse Counselor preferred; OR

2) A Bachelor's degree in Social Work, Clinical Psychology, Nursing or Counseling; with a minimum of six (6) years experience in a child maltreatment prevention and/or intervention program.

C) Child Development Specialist (CDS) shall possess the following qualifications:

1) Master's degree in health and human services; with a minimum of two (2) years experience in an early childhood program (prenatal to three 3 years desirable), OR

2) A Bachelor's degree in health or human services; with a minimum of four (4) years experience in an early childhood program. (prenatal to three 3 years desirable)

D) Family Support Workers with the following minimum education qualifications:

High School degree or GED

Staffing requirements are as follows:

A minimum of one (1) full-time Child Development Specialist (CDS) per site.

A minimum of one (1) full-time Clinical Specialist (CSp) per site.

Clinical Supervisor should not exceed 5 full-time staff.

All Healthy Start staff (FSWs, CSs, CDS, and CSps) receives weekly supervision for a minimum of one (1) hour from the appropriate person as detailed in the Hawaii Healthy Start Program Model.

Supervision includes both case management and reflective supervision components.

Supervision documentation must include 1) Family status including target child; 2) Current concerns and a plan to address the concern

including appropriate resources and referrals, and progress toward IFSP goals, and 3) Strategies for continued engagement/retention of the family.

Caseload of each full-time FSW not to exceed 25 families.

Appropriate agency staff, including but not limited to FSWs, will be assigned according to the identified and prioritized needs of the family.

Flexible work hours shall be granted and scheduled to all staff as necessary in order to provide needed and timely services during evenings, weekends and holidays.

All HHS staff shall receive the training required by Healthy Families America (HFA)/MCHB. All training shall be documented in the MCHB training matrix.

The Awardee ensures that all HHS employees paid from Healthy Start funds meet required qualifications. Any deviation from the above staffing requirement shall require approval by the MCHB and will be determined on a case-by-case basis according to stipulations set by MCHB.

See part II.B of this Section 2 of the RFP for related information about the planned secondary purchase.

2. Administrative

The MCHB/HHS Program Head provides primary direction to the program administrator and staff. Additional MCHB administrative staff who can offer guidance include the FCSS Supervisor and the MCHB Chief, as needed or requested.

The Awardee shall comply with all data entry requirements of the Child Health Early Intervention Record System (CHEIRS) and related data management issues.

The Provider shall comply with all MCHB evaluation measures and data collection standards, formats, and timelines, including, but not limited to the HHS Quality Improvement System (QIP).

The Provider shall be compliant with the following Federal requirements:

Family Education Record Protection Act (FERPA).

Health Insurance Portability Accountability Act (HIPAA) (1995) in areas of privacy, transaction, and security.

The Provider shall be compliant with all HDOH standards and guidelines for implementation, forms, quality improvement system efforts, including monitoring, and reporting requirements, including billing.

3. Quality assurance and evaluation specifications

The Provider shall conform to established standards of care and practice, including, but not limited to the following:

Hawaii Healthy Start Program Model
Healthy Families America Critical Elements **(See Attachment D)**

The Provider shall participate in all required Quality Assurance/Improvement activities to ensure compliance with program standards, including but not limited to the statewide Quality Improvement Plan.

Provider shall take all measures necessary to maintain HFA credentialed status. If not currently credentialed, or in the process of being credentialed, Provider shall begin the credentialing process during the second year of the four year contract, with credentialing to be achieved by the end of the four year contract. This process will be monitored by MCHB.

4. Output and performance/outcome measurements

As a means towards achieving the goal of preventing child maltreatment, MCHB will require the reporting of performance and output measures **(See Attachment F)**. This approach proposes that the Awardee take responsibility for achieving short- term performance objectives that are linked to long-term statewide objectives that measure conditions in their entirety. Defined performance objectives are addressed in the Service Delivery section of the Purchase of Service (POS) Proposal Application. (Refer to Section 3).

Regarding the secondary purchase, the Provider shall provide all services required by the primary purchaser for screening, assessment, and home visiting of families including the ongoing collection of data required by the primary purchaser. Additional performance measures for the secondary purchase are specified on DHS Form A - People to be Served, DHS Form B - Service Activities, and DHS Form C - Outcomes; these forms are included as an attachment in Section 5 of this RFP.

5. Reporting requirements for program and fiscal data

The Provider shall submit all monthly, quarterly and annual written reports on all activities of the program related to Individuals with Disability Act (IDEA), Felix vs. Lingle Consent Decree, MedQUEST and the contract, including program activities, program monitoring, quality improvement, data, training, staffing and other applicable areas according to timelines and formats set by MCHB.

The Provider shall submit to MCHB an annual variance report no later than sixty (60) calendar days after the end of the fiscal year in the format requested by the MCHB, documenting the organization's achievement of performance objectives for the fiscal year and explaining all significant variances plus or minus ten percent (+/-10%) with corresponding description of quality improvement efforts above and beyond the program model to be implemented with appropriate timelines for progress.

Requests for payments will be submitted monthly on an invoice and an encounter report form that prescribes to the Hawaii Healthy Start Billing Policies and Procedures. Compliance and timeliness are monitored by MCHB.

Note: Program and fiscal reporting requirements may change to comply with HIPAA and/or FERPA standards.

Regarding the secondary purchase, the Provider shall furnish all reports required by the primary purchaser as well as quarterly programmatic and fiscal reports requested by the secondary purchaser to document cost reimbursement expenditures and performance levels including but not necessarily limited to items specified on DHS Forms A, B, and C **(See Attachment G)**. Unless otherwise agreed invoices shall be submitted quarterly in a format specified by DHS.

6. The Provider shall make an acknowledgement of the DEPARTMENT and MCHB as the Provider's program sponsor. This acknowledgement shall appear on all printed materials for which the DEPARTMENT is a program sponsor.

7. The Provider shall comply with applicable policies and procedures of the Department of Health.

8. The Provider shall comply with Department of Health's Directive Number 04-01 dated May 3, 2004 related to Interpersonal Relationship Between Staff and Clients/Patients. **(See Attachment J)**

9. Pricing structure or pricing methodology to be used

Fixed rate. FHSD/MCHB will not consider contracting for services with rates above the fixed unit rate.

Unit Cost for the Home Visiting and Child Development and Cost Reimbursement for the Clinical Specialists.

Cost reimbursement for Clinical Specialists. The cost reimbursement pricing structure reflects a purchase arrangement in which the State pays the contractor for budgeted costs that are actually incurred in delivering the services specified in the contract up to a stated maximum obligation.

Applicants will provide a budget for the Clinical Specialist component of the program. Implementation of each professional component must be fully initiated to begin on the first day of the execution of the contract.

10. Units of service and unit rate

The unit of service is a based on a service hour rate of $49.44.

IV. Facilities

Facilities shall be adequate relative to the proposed services.
Facilities must be accessible to all HHS staff and families.

Section 3

Proposal Application Instructions

Section 3
Proposal Application Instructions

General instructions for completing applications:

- *Proposal Applications shall be submitted to the state purchasing agency using the prescribed format outlined in this section.*
- *The numerical outline for the application, the titles/subtitles, and the applicant organization and RFP identification information on the top right hand corner of each page should be retained. The instructions for each section however may be omitted.*
- *Page numbering of the Proposal Application should be consecutive, beginning with page one and continuing through for each section.* ***See sample table of Contents***
- *Proposals may be submitted in a three ring binder (Optional).*
- *Tabbing of sections (Recommended).*
- *Applicants must also include a Table of Contents with the Proposal Application. A sample format is reflected in Section 5, Attachment B of this RFP.*
- *A written response is required for* ***each*** *item unless indicated otherwise. Failure to answer any of the items will impact upon an applicant's score.*
- *Applicants are* ***strongly*** *encouraged to review evaluation criteria in Section 4, Proposal Evaluation when completing the proposal.*
- *It is not sufficient to reiterate the wording of the RFP as narratives for each specific section are written.*
- *Proposals are limited to a maximum of* ***thirty-five (35)*** *written pages (II, III and IV of Section 3 of the RFP).*
- *This form (SPO-H-200A) is available on the SPO website (for the website address see the Proposal Application Checklist in Section 5, Attachments). However, the form will not include items specific to each RFP. If using the website form, the applicant must include all items listed in this section.*

The Proposal Application comprises the following sections:

- *Proposal Application Identification Form*
- *Table of Contents*
- *Program Overview*
- *Experience and Capability*
- *Project Organization and Staffing*
- *Service Delivery*
- *Financial*
- *Other*

V. Program Overview (No more than one page)

Applicant shall give a brief overview to orient evaluators as to the program/services being offered.

VI. Experience and Capability (no more than 5 pages)

A. Necessary Skills

Applicant shall describe skills, abilities, and knowledge necessary for delivery of the proposed services. Applicant shall describe how the described skills, abilities, and knowledge will be successfully applied in the delivery of the proposed services.

B. Experience

Applicant shall describe experience in administration of comparable models/programs/projects/contracts. Applicant shall describe success in meeting project outcomes/performance measures/contract obligations.

C. Quality Assurance and Evaluation

Applicant shall describe a system for continuous quality improvement (use of data, quality control, quality assurance, corrective action plans, quality improvement plans) to ensure achievement of contracted performance objectives. Applicant shall describe a system for ensuring conformity to established standards of care and practice as related to proposed services.

D. Coordination of Services

Applicant shall describe capability (ability and willingness) to coordinate services within and without their own agency to include their local community.

E. Facilities

Applicant shall describe facilities and demonstrate adequacy in relation to the proposed services. Describe plans to secure facilities, if are not currently adequate or not presently available. Describe how the facilities meet ADA requirements, as applicable.

VII. Project Organization and Staffing (no more than 4 pages)

A. Staffing

1. Proposed Staffing

Applicant shall describe proposed staffing and management appropriate for the viability of the services. (Refer to the personnel requirements in the Service Specifications, see Section 2, III.B. Management Requirements)

2. Staff Qualifications

Applicant shall describe approach/system to ensure that all staff assigned to the program meet stated staffing and management requirements and qualifications. (Refer to the qualifications in the Service Specifications, see Section 2, III.B. Management Requirements)

B. Project Organization

1. Supervision and Training

Applicant shall describe ability to supervise, train, and provide administrative direction relative to the delivery of the proposed services.

2. Organization Chart

Applicant shall attach an organization chart reflecting the position of each staff and line of responsibility/supervision and briefly describe approach/system for communication, supervision, training, and provision of administrative direction. (Include position title, name and full time equivalency) Both the "Organization-wide" and "Program" organization charts shall be attached to the Proposal Application.

VIII. Service Delivery (no more than 25 pages)

Applicant shall include a detailed discussion of the applicant's approach to applicable service activities and management requirements from Section 2, Item III. - Scope of Work, including all service activities and tasks to be completed, related work assignments/responsibilities and timelines/schedules.

Applicants shall specify the geographic area to be served, the demographics, and the reasons for selection.

Applicant shall describe the following:

- Types of services they will provide to reduce family stress and prevent the occurrence/reoccurrence of child maltreatment and the type of staff responsible for providing these services.

- Specific strategies to engage and retain families, especially difficult to reach families.

- Specific strategies to identify, assess, address, monitor, and evaluate malleable risk factors associated with child maltreatment/poor child outcomes.

- Specific strategies to motivate families to seek community resources and services when necessary.

- Approach they will utilize to enhance communication, socialization and parenting skills including a positive discipline approach.

- A case management/care coordination system for the purpose of coordinating the utilization of community resources.

Applicant shall describe the role of the upper management staff (anyone beyond the CS on the organizational chart), to include but not be limited to:

- Approach utilized to develop Memorandum of Agreements/Understanding and referrals to community agencies/programs.

- Provisions of community education to enhance awareness of child maltreatment dynamics and intervention strategies, and HHS services.

- Approach utilized to manage data and the quality assurance/quality improvement system (including corrective action plans) to ensure achievement of contracted performance objectives.

Applicants shall describe the role of the Clinical Supervisor (CS) in the case management/care coordination system, to include but not be limited to:

- Supporting, guiding and providing case management to identify, assess, strategize, address, monitor and evaluate malleable risk factors associated with child maltreatment/poor child outcomes.

- Utilization and incorporation of the IFSP into home visiting services.

- Providing reflective supervision to staff to address staff related issues, such as burnout and turnover.

- Developing and maintaining community resources, referrals, and support linkages to fully meet the needs of multi-problem families within the specific geographic area, including prenatal families. This includes an emphasis on the medical home providers, such as pediatricians and obstetricians-gynecologists.

- Ensuring coordinated utilization of community resources for the multi-need family from a variety of providers, both within and outside the agency and across agencies/programs.

- Tracking, planning, monitoring, and supporting staff utilization and development of skills and to recommend training opportunities as appropriate and/or required.

Applicants shall describe implementation of the Clinical Specialist (CSp) model **[See Attachment H – The CSp Model for additional details.]** into the case management/care coordination system, including but not limited to:

- How to identify families' stage of change and develop strategies to support and motivate families to seek and receive treatment and counseling in areas which include but not limited to substance use, intimate partner abuse and mental health issues.

- Completing a psychosocial assessment and a care plan for families who are experiencing personal and/or emotional problems.

- Providing up to three (3) months of short-term intervention with strategies to work through the families' denial process and to motivate families to seek long-term treatment and/or counseling in appropriate areas.

- Tracking and documentation of referrals.

- Integration of services into the IFSP.

- Training for families and staff.

Applicants shall describe implementation of the Child Development Specialist (CDS) model **[See Attachment I – The CDS Model for additional detail]** into the case management/care coordination system, to include but not be limited to:

- Monitoring development and health status of the child utilizing MCHB specified screening instruments Ages & Stages Questionnaire (ASQ), Ages & Stages Questionnaire – Social Emotional (ASQ-SE), the Home Observation for Measurement of the Environment (HOME) and the Nursing Child Assessment Satellite Training (NCAST) TEACH.

- Approach to refer a child with suspected developmental delay to the medical home and public/private community agencies.

- Intervention strategies and their respective parameters.

- Tracking and documentation of all referrals.

- Integration of services into the IFSP.

- Training for all families and staff.

Applicants shall describe utilization of the team approach to promote and support areas of children's social-emotional, language and cognitive development to include but not be limited to:

- Bonding and attachment
- Brain development
- Parent's observation skill and role as first and most important teacher.
- Positive child rearing practices (non-punitive punishment)

Applicants shall describe utilization of the teams approach to promote and support areas of family health and safety to include but not be limited to:

- Identification and utilization of the medical home to provide recommended well child visits, immunizations, and sick care.
- Identification and utilization of the dental home to provide recommended dental health.
- Injury prevention.
- Cessation of substance use, including smoking.
- Positive pregnancy outcomes via early and continuous prenatal care.
- Family planning (adequate birth spacing).
- Healthy diet and exercise.

Applicants shall describe how they will promote family stability and wellness including but not limited to:

- Promoting family life skills.
- Promoting violence free homes.
- Promoting nurturing relationships within the family.

A. Management Requirements

Applicants shall identify their baseline for the Healthy Start performance measures. Given available resources and other external factors, the applicant shall formulate both reasonable and achievable performance objectives, and the approach to be taken in meeting these objectives for the multi-year contract period. Please refer to Table A (Performance Measures) which should be completed and attached to the POS Application Proposal. These tables may be found in Section 5, **Attachment E** of this RFP.

A description of plans to meet HIPPA standards should be attached.

IX. Financial

A. Pricing Structure

Applicant shall submit a cost proposal utilizing the pricing structure designated by the state purchasing agency. The cost proposal shall be attached to the Proposal Application.

1. Pricing Structure Based on Fixed Rate

If a state purchasing agency is utilizing a fixed rate pricing structure for the RFP, the applicant is requested to furnish a reasonable estimate of the maximum number of service units it can provide for which there is sufficient operating capacity (adequate, planned and budgeted space, equipment and staff). The following form(s) shall be submitted with the POS Proposal Application:

- Form C-3 (See Attachment J)
- Form SPO-H-206C (See SPO Website @ www.spo.hawaii.gov)

2. Pricing Structure Based on Cost Reimbursement

The cost reimbursement pricing structure reflects a purchase arrangement in which the State pays the contractor for budgeted costs that are actually incurred in delivering the services specified in the contract up to a stated maximum obligation.

The following budget form(s) shall be submitted with the POS Proposal Application (See SPO Website @ www.spo.hawaii.gov):

- Form SPO-H-205
- Form SPO-H-206A
- Form SPO-H-206B
- Form SPO-H-206C

All budget forms, instructions and samples are located on the SPO website (see the Proposal Application Checklist in Section 5 for website address). The following budget form(s) shall be submitted with the Proposal Application:

B. Other Financial Related Materials

1. Accounting System

In order to determine the adequacy of the applicant's accounting system as described under the administrative rules, the following documents are requested as part of the Proposal Application (may be attached):

X. Other

A. Litigation

The applicant shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.

Section 4

Proposal Evaluation

Section 4
Proposal Evaluation

I. Introduction

The evaluation of proposals received in response to the RFP will be conducted comprehensively, fairly and impartially. Structural, quantitative scoring techniques will be utilized to maximize the objectivity of the evaluation.

II. Evaluation Process

The procurement officer or an evaluation committee of designated reviewers selected by the head of the state purchasing agency or procurement officer shall review and evaluate proposals. When an evaluation committee is utilized, the committee will be comprised of individuals with experience in, knowledge of, and program responsibility for program service and financing.

The evaluation will be conducted in three phases as follows:

- Phase 1 - Evaluation of Proposal Requirements
- Phase 2 - Evaluation of Proposal Application
- Phase 3 - Recommendation for Award

Evaluation Categories	**Maximum Points**
Administrative Requirements	
Proposal Application	
Program Overview	0 points
Experience and Capability	20 points
Project Organization and Staffing	10 points
Service Delivery	70 points
Financial	0 points
TOTAL MAXIMUM POINTS	**100 points**

A point scale will be used to rate the proposal content. Each item shall be rated on a 5-point scale. A proposal response that did not address required elements (unsatisfactory) will be rated as a 1 (one). A proposal that met all required elements (satisfactory) will be rated as a 3 (three). A proposal that exceeded required elements and was more comprehensive in explanation and detail (exceptional) will be rated a 5 (five). Points will be assigned according to the evaluation criteria.

Place Value 1 2 3 4 5
unsatisfactory I----------I----------I----------I----------I **exceptional**
satisfactory

III. Evaluation Criteria

A. Phase 1 - Evaluation of Proposal Requirements

1. Administrative Requirements
2. Proposal Application Requirements

- Proposal Application Identification Form (Form SPO-H-200)
- Table of Contents
- Program Overview
- Experience and Capability
- Project Organization and Staffing
- Service Delivery
- Financial (All required forms and documents)
- Program Specific Requirements (as applicable)

B. Phase 2 - Evaluation of Proposal Application (100 Points)

Program Overview: No points are assigned to Program Overview. The intent is to give the applicant an opportunity to orient evaluators as to the service(s) being offered.

1. *Experience and Capability (20 Points)*

A maximum of 5 points will be assigned to each bullet below.

The State will evaluate the applicant's experience and capability relevant to the proposed services, which shall include:

A. Necessary Skills

- Description of skills, abilities, and knowledge necessary for the delivery of the proposed services and how the described skills, abilities, and knowledge will be successfully applied in the delivery of the proposed services.

B. Experience

- Description of experience in administration of comparable models/programs/projects/contracts and success in meeting project outcomes/performance measures/contract obligations.

c. Quality Assurance and Evaluation

- Description of a system for continuous improvement (use of data, quality control, quality assurance, corrective action plans, quality improvement systems) to ensure achievement of contracted performance objectives and conformity to established standard of care and practice as related to proposed services.

d. Coordination of Services

- Description of capability (ability and willingness) to coordinate services within applicant's own agency and across related and/or pertinent agencies, programs, and resources within the community and across the State.

e. Facilities (no points assigned)

- Facilities relative to the proposed services must meet ADA requirements.

2. ***Project Organization and Staffing (10 Points)***

A maximum of 5 points will be assigned to each bullet below

The State will evaluate the applicant's overall staffing approach to the proposed services, which shall include:

a. Project Organization

- Description of ability to supervise, train, communicate, and provide administrative direction relative to the delivery of the proposed services. [Attachment of an organizational chart reflecting the position of each staff and line of responsibility/supervision required.]

b. Staffing

- Description of proposed staffing and management

appropriate for the viability of the proposed services with description of approach/system to ensure that all staff assigned to the program meet stated staffing and management requirements and qualifications.

3. ***Service Delivery (70 Points)***

A maximum of 5 points will be assigned to each bullet below.

The State will evaluate the applicant's detailed discussion of approach to applicable service activities and management requirements, which shall include:

- Description of services provided to reduce family stress and prevent the occurrence/reoccurrence of child maltreatment and the type of staff responsible for providing these services.

- Description of specific strategies to engage and retain families, especially difficult to reach families.

- Description of specific strategies to identify, assess, address, monitor, and evaluate malleable risk factors associated with child maltreatment/poor child outcomes.

- Description of specific strategies to motivate families to seek community resources and services when necessary and Description of a case management/care coordination system for the purpose of coordinating the utilization of community resources

- Description of approach utilized to enhance communication, socialization and parenting skills including a positive discipline approach.

- Description of the role of the upper management staff (anyone beyond the CS on the organizational chart), to include but not be limited to: 1) Approach utilized to develop Memorandum of Agreements/Understanding and referrals to community agencies/programs; 2) Provisions of community education to enhance awareness of child maltreatment dynamics and intervention strategies, and HHS services; and, 3) Approach utilized to manage data and the quality assurance/quality improvement system (including corrective action plans) to ensure achievement of contracted performance objectives.

A maximum of 10 points will be assigned to each bullet below

- Description of the role of the Clinical Supervisor (CS) in the case management/care coordination system, to include but not be limited to: 1) Supporting, guiding and providing case management to identify, assess, strategize, address, monitor and evaluate malleable risk factors associated with child maltreatment/poor child outcomes; 2) Utilizing and incorporating the IFSP into home visiting services; 3) Providing reflective supervision to staff to address staff related issues, such as burnout and turnover; 4) Developing and maintaining community resources, referrals, and support linkages to fully meet the needs of multi-problem families within the specific geographic area, including prenatal families [This includes an emphasis on the medical home providers, such as pediatricians and obstetricians-gynecologists]; 5) Ensuring coordinated utilization of community resources for the multi-need family from a variety of providers, both within and outside the agency and across agencies/programs; and 6) Tracking, planning, monitoring, and supporting staff utilization and development of skills and to recommend training opportunities as appropriate and/or required.

- Description of implementation of the Clinical Specialist (CSp) model **[See Attachment H – The CSp Model for additional details]** into the case management/care coordination system, including but not limited to: 1) Identification of families' stage of change and develop strategies to support and motivate families to seek and receive treatment and counseling in areas which include but not limited to substance use, intimate partner abuse and maternal health issues; 2) Completion of a psychosocial assessment and a care plan for families who are experiencing personal and/or emotional problems; 3) Conducting three (3) months of short-term intervention with strategies to work through the families' denial process and to motivate families to seek long-term treatment and/or counseling in appropriate areas; 4) Tracking and documenting referrals; 5) Integrating services into the IFSP; and, 6) Training for staff.

- Description of implementation of the Child Development Specialist (CDS) model **[See Attachment I – The CDS Model for additional detail]** into the case management/care coordination system, to include but not be limited to: 1) Monitoring development and health status of the child utilizing MCHB specified screening instruments Ages & Stages Questionnaire (ASQ), Ages & Stages Questionnaire – Social Emotional (ASQ-SE), the Home Observation for Measurement of the Environment (HOME) and the Nursing Child Assessment Satellite Training (NCAST) TEACH; 2) Referring a child with suspected developmental delay to the medical home and public/private community agencies; 3) Providing

intervention strategies and their respective parameters; 4) Tracking and documentation of all referrals; 4) Integrating services into the IFSP; and, 5) Training for all families and staff.

- Description of utilization of the team approach to promote and support areas of:

  - Children's social-emotional, language and cognitive development to include but not be limited to: 1) Bonding and attachment; 2) Brain development; 3) Parent's observation skill and role as first and most important teacher; and, 4) Positive child rearing practices (non-punitive punishment).

  - Family health and safety to include but not be limited to: 1) Identification and utilization of the medical home to provide recommended well child visits, immunizations, and sick care; 2) Identification and utilization of the dental home to provide recommended dental health; 3) Injury prevention; 4) Cessation of substance use, including smoking; 5) Positive pregnancy outcomes via early and continuous prenatal car; 6) Family planning (adequate birth spacing); and, 7) Healthy diet and exercise.

  - Family stability and wellness including but not limited to: 1) Family life skills; 2) Violence free homes; and, 3) Nurturing family relationships.

5. ***Financial***

Pricing structure based on fixed price

No points are assigned to Financial. Attachment and completion of Training/Travel budget required only for Applicants applying for the islands of Kauai, Hawaii, Maui and Molokai. Attachment and completion of C-3 and SPO-H-206C-Adequacy of accounting system required for all Applicants.

- **Phase 3 - Recommendation for Award**

Each notice of award shall contain a statement of findings and decision for the award or non-award of the contract to each applicant.

Section 5

Attachments

A. Competitive Proposal Application Checklist

B. Sample Proposal Table of Contents

C. Hawaii Healthy Start Program Model

D. Healthy Families America Critical Elements

E. Performance Measures

F. Output Measures

G. Department of Human Services' Form A, B, & C

H. Clinical Specialist Model

I. Child Development Specialist Model

J. Form C-3 Performance Based Budget

K. Department of Health's Directive Number 04-01 dated May 3, 2004

Attachment A

Proposal Application Checklist

Proposal Application Checklist

Applicant: _____ RFP No.: _____

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the state purchasing agency as part of the Proposal Application. *SPO-H forms are located on the web at http://www.spo.hawaii.gov Click *Procurement of Health and Human Services* and *For Private Providers.**

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
General:				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	**X**	
Proposal Application Checklist	Section 1, RFP	Attachment A	**X**	
Table of Contents	Section 5, RFP	Section 5, RFP	**X**	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	**X**	
Registration Form (SPO-H-100A)	Section 1, RFP	SPO Website*	**(Required if not Registered)**	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*	**X**	
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions is applicable, Section 5	**X**	
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions, Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*		
SPO-H-206B	Section 3, RFP	SPO Website*	**X**	
SPO-H-206C	Section 3, RFP	SPO Website*	**X**	
SPO-H-206D	Section 3, RFP	SPO Website*	**X**	
SPO-H-206E	Section 3, RFP	SPO Website*		
SPO-H-206F	Section 3, RFP	SPO Website*		
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*		
SPO-H-206I	Section 3, RFP	SPO Website*		
SPO-H-206J	Section 3, RFP	SPO Website*		
Certifications:				
Federal Certifications		Section 5, RFP		
Debarment & Suspension		Section 5, RFP		
Drug Free Workplace		Section 5, RFP		
Lobbying		Section 5, RFP		
Program Fraud Civil Remedies Act		Section 5, RFP		
Environmental Tobacco Smoke		Section 5, RFP		
Program Specific Requirements:				

_____ _____

Authorized Signature Date

SPO-H (Rev. 9/04)

Attachment B

Sample Table of Contents

Organization: _____
RFP No: _____

Proposal Application
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Program Model

August, 2004

Hawai'i Department of Health

Hawai'i's Healthy Start (HHS) began as a demonstration child abuse and neglect prevention project in July 1985 in one location on Oahu. HHS served as the model for the home visiting program initiated on the mainland by Prevent Child Abuse America, Healthy Families America (HFA). Today HHS has evolved into a systemic and comprehensive family support service for environmentally at-risk families. These families require extra support, guidance, education, and information to ensure that their children are physically, emotionally and developmentally healthy and safe. HHS is part of the State's (via the Hawai'i State Department of Health) accepted plan to provide required services for children ages 0 to 3 years [Part B] under the Federal Individuals with Disabilities Education Act (IDEA), and the Felix vs. Lingle Consent Decree. As such, HHS is part of the Early Intervention (EI) System. The EI System includes:

- Early Intervention Section, Children with Special Health Needs Branch, Family Health Services Division;
- Public Health Nursing, Public Health Nursing Branch, Family Health Services Division; and,
- Healthy Start, Family and Community Support Section, Maternal and Child Healthy Branch, Family Healthy Services Division.

HHS has historically offered focused support services within a families' natural environment to reduce the likelihood of child maltreatment by reducing parental/environmental stressors, including establishment and utilization of a medical home, linkages with community resources such as health and mental health services, early childhood education, childcare, family literacy, employment, and social services, developmental screening and appropriate child development education/interventions, service coordination and advocacy for families, and providing parents with knowledge of child development, child health, and positive parenting skills and problem-solving techniques. Research strongly supports the family stress perspective of environment (employment, housing, income, etc.) affecting parental stress and behavior, which in turn influences family processes. Parents faced with environmental hardships tend to be more punitive and less warm in their parenting techniques, resulting in children who are more likely to act out. Hence, the importance of the parent-child relationship and its impact on child maltreatment.

HHS focuses equally on building family resiliency and supporting child development. Critical HHS components include:

- Engagement and retention of families and related creative outreach efforts;
- Decreasing stress, chaos, and disorganization of families via the Level Movement System [a primary indicator of program success];
- Individual Family Support Plan (IFSP) [a primary indicator of family success and the main tool of service provision within the EI System]; and,
- Identifying, assessing, strategizing, addressing, monitoring, and evaluating malleable risk factors associated with child maltreatment/poor child outcomes.

HHS utilizes a para-professional model. Family Support Workers (FSW) are the primary contact with the family although a team of professional specialists work closely with the FSW in strengthening the family. These specialists include the Clinical Supervisor (CS), the Child Development Specialist (CDS), and the Clinical Specialist (CSp). All staff are selected because of a combination of personal characteristics, experiential, and education qualifications. [See HFA Critical Element 9 (Attachment D) for additional detail.]

The role of the CDS is to support optimal child growth and development utilizing a variety of appropriate developmental screening tools and timely intervention strategies with families and HHS staff. As such, this position is integral to the effective delivery of services for children with suspected developmental delays. Once the appropriate developmental screens are administered and reviewed, the CDS is responsible for timely referral of children to Early Intervention Section for Comprehensive Developmental Evaluation (CDE), following the child through service and supporting the family, and guiding the family and FSW on developmentally appropriate activities, via group activities and individual consultations, to enhance EI Services. The CDS may also be involved in coordinating developmental services for a family should the evaluation deem those services necessary. For those families initially refusing referral, the CDS works with them to help understand the nature of the suspected delay and to accept the referral. Finally, the CDS works with those who continue to have concerns but are not determined to be developmentally delayed. [See CDS Model – Attachment I].

The CSp position to specifically addresses challenges of parents with substance use (including smoking), intimate partner abuse, and mental health issues that can impact program services aimed at child development and parent-child interactions when the parent is emotionally and psychologically unavailable. The CSp position works with these environmental risk factors of HHS parental/primary caregiver via referrals and resources, consultation and education, and

support. The focus is on the Stages of Change model and "treatment readiness" support to work with families in accepting, engaging in, remaining engaged in outside professional long-term treatment, and recovery support services. [See CSp Model – Attachment H].

The goals of Healthy Start are as follows:

a. To systematically assess, identify and offer services to those families needing extra support among all civilian birth families in the State of Hawaii as well as all prenatal referrals. To refer families to community resources as needed, including HHS home visiting programs.
b. To enhance family functioning by teaching problem solving skills, and improving the family's formal and informal support system. To provide linkages to community services to enhance parent, child and family wellness.
c. To promote positive parent-child interaction which will enhance bonding and reduce the likelihood of child maltreatment
d. To promote healthy childhood growth and development to enhance physical, emotional and developmental health.

HHS is committed to continuous quality improvement. Inherent to the model is the Hawaii Healthy Start Quality Improvement System, in which all providers participate in the development/revision of and strictly adhere to. The goals of HHS are grounded in research and best practice, and are accomplished in two major service components: 1) Early Identification (EID) provides population-based, in-hospital screening/assessment/referral to identify environmentally at-risk infants plus screening/assessment of referred pre-natal families; and, 2) Home Visiting (HV) provides intensive, focused family support addressing the environmental risk factors.

EID Services:

Best practice indicates that all civilian families of newborns are screened/assessed in a face-to-face meeting within twenty-four (24) to forty-eight (48) hours after delivery but no later than fourteen (14) days of birth. Best practice indicates that referral to the HV component should be complete within another twenty-four (24) to forty-eight (48) hours after screen/assessment/referral has been accepted. A short-time line is critical to engagement and retention of high risk families. Program eligibility is up to one (1) year from birth. All referred prenatal moms are screened/assessed no later than fourteen (14) days from referral and are then

referred for home visiting services within twenty-four (24) to forty-eight (48) hours. MCHB determines the standardized screen/assessment tool. If they screen positive from the MCHB determined 15 point checklist, they are assessed using the MCHB determined standardized assessment tool [C. Henry Kempe's Family Stress Checklist] to determine environmental risk. This tool assesses the presence of various factors associated with increased risk for child maltreatment such as social isolation, substance abuse, family violence, lack of parenting skills, parents' history of child abuse, and stress inducing circumstances in the home. In addition, families who are active with Child Welfare Services may be referred for intake services within twelve (12) months of birth. For families who do not assess positive for the presence of the risk factors, referrals to other community resources may be made as needed. For those who would benefit from Healthy Start home visiting services, referrals are made to the Healthy Start home visiting program located in their area of residence. Services initiated pre-natally or at birth reach parents when they are most amenable to information and assistance. Once parenting patterns have been established, it is much more difficult to effect change.

Early Identification teams of Family Assessment Workers (FAW) visit all civilian hospitals with birthing services daily to enable screening/assessment/referral for one hundred percent (100%) of postnatal families. Families who have already been discharged are followed up by phone screens/assessments. Prenatal families may be self-referred or referred by doctors, Public Health Nurses, and prenatal programs in the community.

HV Services

Home Visiting (HV) services are intensive based on the perceived functioning of the family and the developmental needs of the child. HV services are voluntary, culturally competent and intended to continue until the child is three years of age (or five years of age if there is a younger target child).

Direct services include:

1). Informed support, advocacy and referrals for families based on the risk factors identified at intake;

2). Identifying, assessing, strategizing, addressing, monitoring, and evaluating malleable risk factors associated with child maltreatment/poor child outcomes.

3.) Developmental screens and environmental assessments at regular intervals;

4.) Linking families to a medical home with insurance for the family and child;

5.) Parenting education to include parent-child interaction skills, child development information and non-violent discipline strategies;
6.) Health information and referrals regarding well-baby care, family planning, prenatal care and child immunization needs; and,
7.) Problem solving skills and guidance on developing family resiliency through the Individual Family Support Plan as required by IDEA Part C guidelines and the HHS Level Movement System.

Level Movement System

Families accepting services when assessed positive to receive weekly home visits for at least six (6) months following the birth of an identified target child. The frequency of home visits is gradually decreased based upon improved family functioning and circumstances as well as the completion of programmatic requirements, which reflect program goals, i.e., developmental screens, immunizations. Family Support Workers (FSW) attempt to accommodate parents who, because of extenuating circumstances, cannot meet during the normal week by providing creative and flexible solutions, including evening and weekend visits. All contacts with families are documented. When the family is referred to Home Visiting services, the Clinical Supervisor (CS) should review all intake information to identify and monitor risk factors/family stressors and guide the FSW as appropriate to provide specific family focused services including resources and referrals. This information is also used to focus service efforts at each Level. For example, a family experiencing violence, specifically intimate partner violence, would have specific issues related to problem solving and conflict resolution, child safety, positive support, and an emergency plan.

The CS and FSW regularly review the family's Level Status to determine promotion to the next Level, or for possible movement to a more intensive Level. All Level movement is documented using the appropriate Level Forms with supporting documentation (i.e., home visitation record, Individual Family Support Plan (IFSP), supervision notes). Families are to be promoted only upon completely meeting all requirements as defined in each Level.

Level P – Prenatal (Pre-engagement)
Level IA – Postnatal Engagement
Level I – Engaged In Service (Crisis Management & Stress Stabilization)
Level II – Retained in Service
Level III – Continued Service (Changeable risk factors reduced /less chaos & more organization)
Level IV – Maintenance
Level X – Engagement/Retention Efforts (Outreach)
Level E – Extreme Scheduling Circumstances

Participants entering prenatally are not subject to IDEA, Part C guidelines as the target child has not yet been born and, as such, this service is considered pre-engagement.

Discharges should address remaining and/or continuing areas of family strengths, concerns and priorities as well as assessment of risk factors and related transition activities/strategies.

HHS Training System:

In addition to having personal dispositions and skills that prepare them for their role, service providers must also receive formal training to develop the knowledge and skills necessary to achieve program goals. Formal training provides an understanding of Healthy Start goals and provides the "how to" link between theory and practice. Training enhances the service provider's ability to sensitively transmit information to families and to promote change in negative parenting behaviors (Weiss, 1993). Service providers must possess many skills and significant knowledge to work with families who are unique and present specific challenges. They must not only be skilled in the identification of risk factors but in strategies to motivate families to address change. Insights acquired from training meet these broad challenges in order to facilitate change and to develop an atmosphere of trust.

A commitment to training:

- Provides the opportunity for service providers to receive and share information and experiences and to develop and implement practical approaches in a safe environment;
- Benefits service providers by acknowledging frustrations and providing support and education. Training also promotes staff professional development; and,

- Insures consistent and comprehensive delivery of services to meet standards of service delivery.

All training provided by MCHB via the HHS training contract will comply with the HHS Training System. Although the HHS Training System does supply a significant portion of training requirements as determined necessary for HFA credentialing, the HHS Training System does not meet all training needs. Contracted Purchase of Service Providers (POSP) must support the HHS Training System fully. In addition, POSP must supply all required training whether or not it is delivered via the HHS Training Contract. Service Providers, to include Family Assessment Workers, Family Support Workers, Child Development Specialists, Clinical Specialists, Clinical Supervisors, Managers and Directors, must receive intensive training specific to their role to understand the essential components of family assessment and home visitation according as well as varied and consistent advanced training according to stated HFA critical elements and stated HHS training requirements.

ACKNOWLEDGEMENTS

The Hawai'i Healthy Start Program Model has evolved over time with many participants adding to the efficacy and quality of services. MCHB thanks all who have supported and contributed, including but not limited to:

Program Pioneers:
- Loretta Fuddy
- Dr. Calvin Sia
- Patti Lyons
- Gail Breakey

HDOH:
- Dr. Chiyome L. Fukino
- Dr. Linda Rosen

MCHB:
- Althea Momi Kamau
- Mitzi Leblon
- Gladys Wong

Research Evaluators:
- Johns Hopkins University
- University of Hawaii-Manoa

Community Partners including:

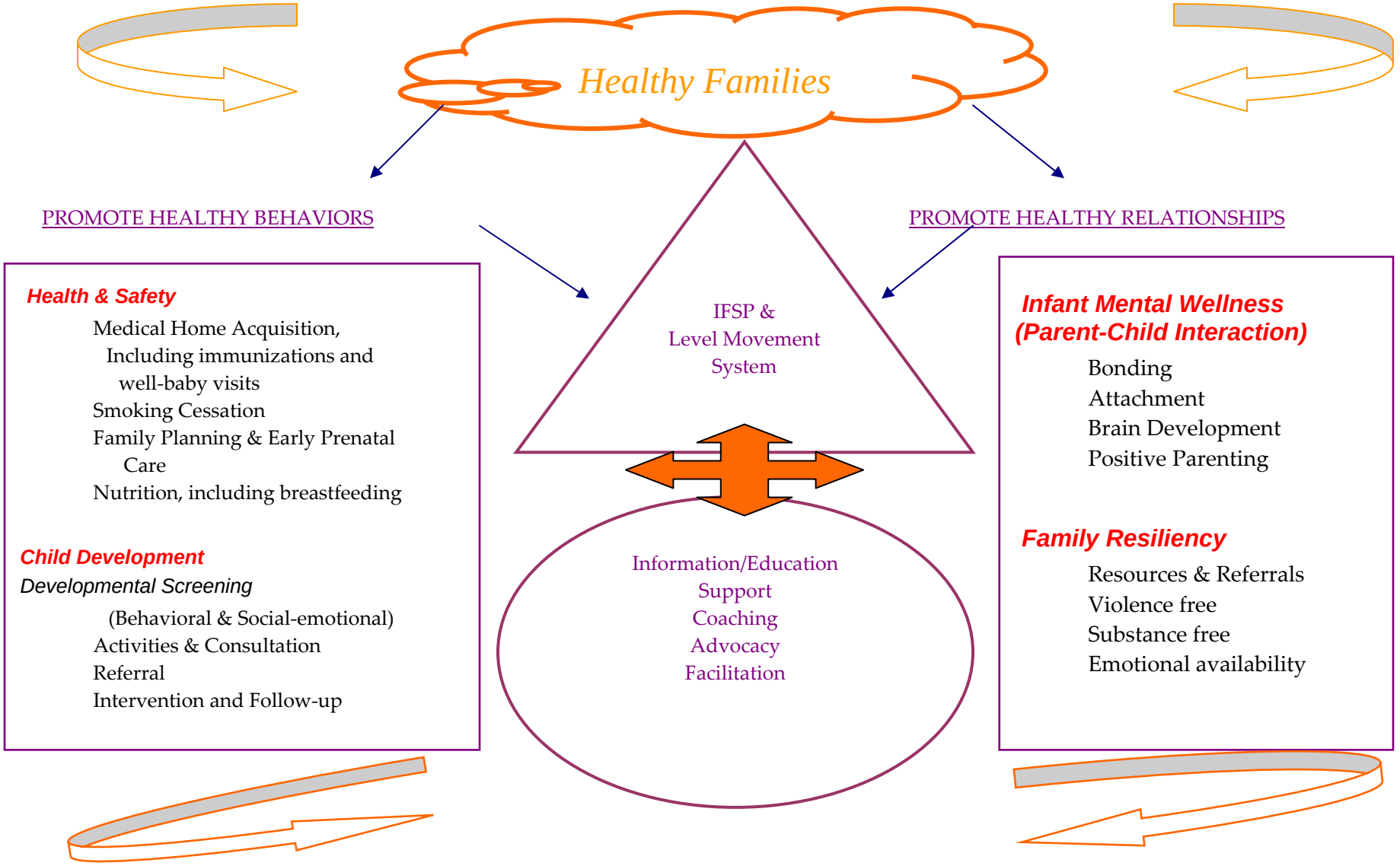
- People and Children Together
- Catholic Charities
- Hawai'i Family Support Center
- Maui Family Support Services
- West Hawai'i Family Support Services
- YMCA of Hawai'i Island
- Child and Family Services
- Molokai Family Support
- Personal Parenting Assessment Services, Inc.

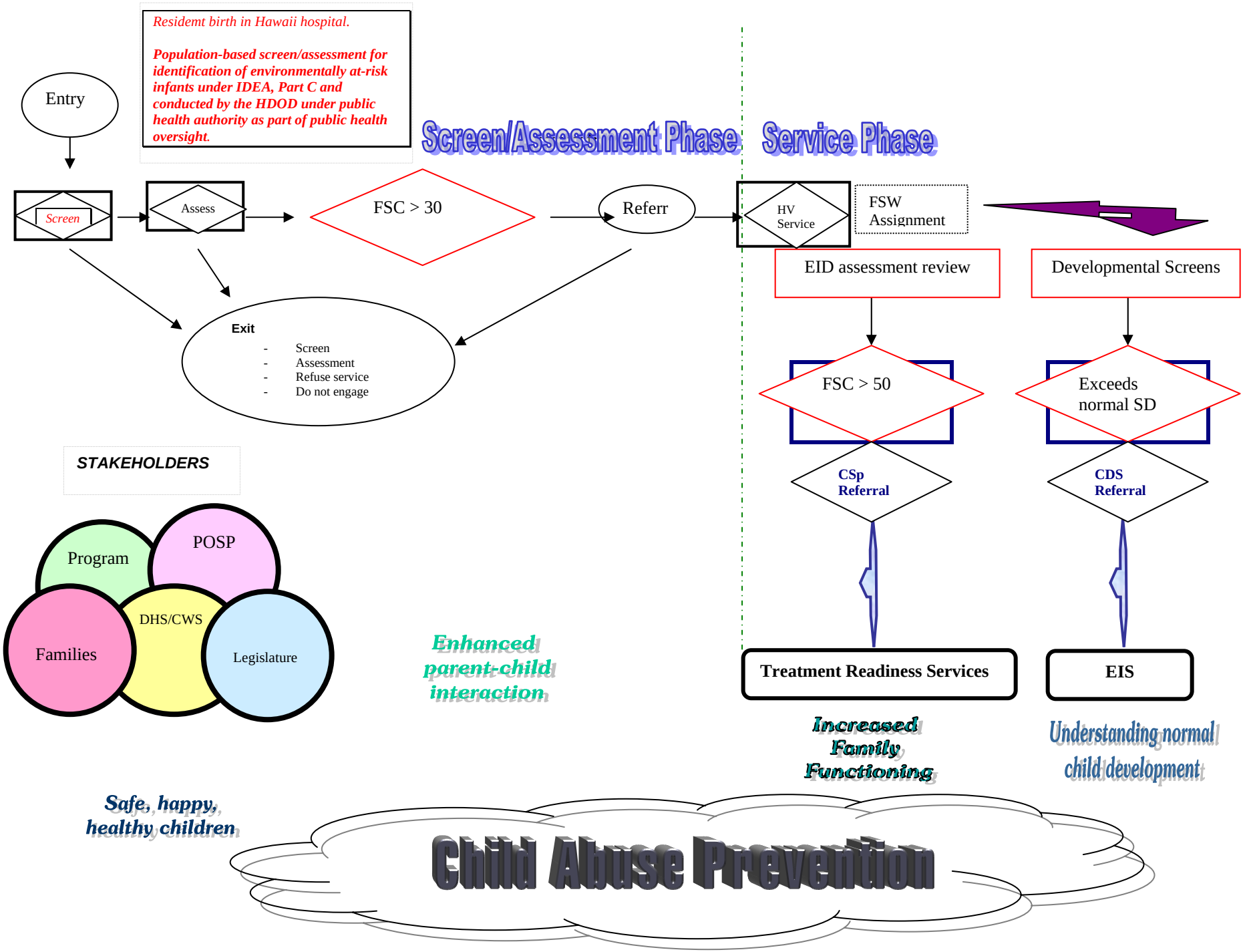
for leadership, collaboration, and belief in the model. MCHB looks forward to the continuing partnership in the service to families to reduce likelihood of child maltreatment.

EARLY INTERVENTION SERVICES - HEALTHY START

Child Maltreatment Prevention for Environmentally At-Risk Children and Families

Assess and monitor risk factors to provide family specific services to reduce family stressors/environmental risk




Residemt birth in Hawaii hospital.
Population-based screen/assessment for identification of environmentally at-risk infants under IDEA, Part C and conducted by the HDOD under public health authority as part of public health oversight.
Entry
Screen/Assessment Phase
Service Phase
Screen
Assess
FSC > 30
Referr
HV Service
FSW Assignment
EID assessment review
Developmental Screens
Exit
- Screen
- Assessment
- Refuse service
- Do not engage
FSC > 50
Exceeds normal SD
CSp Referral
CDS Referral
STAKEHOLDERS
Program
POSP
DHS/CWS
Families
Legislature
Enhanced parent-child interaction
Treatment Readiness Services
EIS
Increased Family Functioning
Understanding normal child development
Safe, happy, healthy children
Child Abuse Prevention

Hawaii Healthy Start Quality Improvement System

Hawai'i Healthy Start (HHS) is part of the State's accepted plan to provide required services for children ages 0 to 3 years [Part B] under the Federal Individuals with Disabilities Education Act (IDEA), and the Felix vs. Lingle Consent Decree. HHS has historically offered focused support services within a families' natural environment to reduce the likelihood of child maltreatment by reducing parental/environmental stressors, including establishment and utilization of a medical home, linkages with community resources such as health and mental health services, early childhood education, childcare, family literacy, employment, and social services, developmental screening and appropriate child development education/interventions, service coordination and advocacy for families, and providing parents with knowledge of child development, child health, and positive parenting skills and problem-solving techniques. Research strongly supports the family stress perspective of environment (employment, housing, income, etc.) affecting parental stress and behavior, which in turn influences family processes. Parents faced with environmental hardships tend to be more punitive and less warm in their parenting techniques, resulting in children who are more likely to act out. Hence, the importance of the parent-child relationship and its impact on child maltreatment.

Inclusion under the Felix Consent Decree resulted in additional specialized services to more fully support both the child and the family of the child around issues of early developmental screening (Child Development Specialist) and predominant environmental risk factors of substance use, intimate partner abuse/family violence, and mental health issues (Clinical Specialist).

Child Development Specialist (CDS)

The role of the CDS is to support optimal child growth and development utilizing a variety of appropriate developmental screening tools and timely intervention strategies with families and HHS staff. As such, this position is integral to the effective delivery of services for children with suspected developmental delays. Once the appropriate developmental screens are administered and reviewed, the CDS is responsible for timely referral of children to Early Intervention (EI) Section (EIS) for Comprehensive Developmental Evaluation (CDE), following the child through service and supporting the family, and guiding the family and Family Support Workers (FSW) on developmentally appropriate activities, via group activities and individual consultations, to enhance EIS. The CDS may also be involved in coordinating developmental services for a family should the evaluation deem those services necessary. For those families initially refusing referral, the CDS works with them to help understand the nature of the suspected delay and to accept the referral. Finally, the CDS works with those who continue to have concerns but are not determined to be developmentally delayed.

During FY03 there were a total of 4,675 children served by HHS. The Ages and Stages Questionnaire (ASQ) is a screening tool to monitor child development. Table 1. below summarizes that there were 177 children identified having at least a two standard deviation (2SD) below the mean for normal development within each particular age range in one domain on the ASQ [indicating immediate referral to Early Intervention (EI) Section for Comprehensive Developmental Evaluation (CDE) which confirms a developmental delay.] 96.2% of HHS children were developmentally on-track.
Similar efforts have been implemented for the Ages and Stages Questionnaire - Social-Emotional (ASQ-SE) in FY04.

Clinical Specialist (CSp)

Trend data analysis suggested that three primary environmental risk factors were increasing for eligible HHS families and qualitative data suggested a model efficacy issue for program services aimed at child development and parent-child interactions where the parent is emotionally and psychologically unavailable. The role of the CSp position is to specifically address environmental risk factors of HHS parental/primary caregiver substance use (including smoking), intimate partner abuse/family violence, and mental health issues via referrals and resources, consultation and education, and support. The focus is on the Stages of Change model and "treatment readiness" support to work with families in accepting, engaging in, remaining engaged in outside professional long-term treatment, and recovery support services.

During FY03 there were a total of 4,213 families served by HHS and, according to quarterly reports submitted by POSP, 1,894 were newly admitted (45%). Of these newly enrolled families, 31.5% (n = 596) indicated high stress in environmental risk areas associated with child abuse and neglect. 100% of these families were referred to and served by the CSp via a variety of strategies not limited to treatment readiness including provision of appropriate resources and referrals, consultations with the FSW supporting the family, group activities and information, and aftercare recovery and support.

Utilizing Social Learning theory with the "strength-based" approach (enhanced self-efficacy), Healthy Start seeks to increase family functioning and enhance positive parent-child interactions to support normal child development and promote safe, healthy, and happy children.

The HHS model is dynamic and based on continuous quality improvement. The Hawaii Department of Health (HDOH) and the HHS Network have a history of attentiveness to the model and priority to meeting the ever-increasing needs and environmental risk of families. Evaluation results, data from CHEIRS, and identified best practice from the field are utilized to enhance quality of service delivery and drive program improvement.

HHS Quality Improvement System

The Quality Improvement System includes training, quality control and quality assurance. Such activities are necessary to ensure full:

- Implementation of the program model;
- Utilization of Healthy Start's Standards and Guidelines;
- Compliance with contract, Felix and Federal IDEA mandated service requirements by the seventeen (17) Purchase of Service Provider (POSP) program sites throughout the state; and,
- Collaboration with the Early Intervention Section in the development of a statewide early intervention system.

Defining boundaries with Early Intervention Section and focusing efforts as a provider has been a priority in FY2004. Healthy Start administrative staff have taken active roles in establishing an integrated and cohesive early intervention system for children age 0 to 3 years. Areas being revised in conjunction with Early Intervention Section and Public Health Nursing Branch are training, supervision, and the Individualized Family Support Plan (IFSP).

The Healthy Start Policies and Procedures are currently being updated and revised with an implementation date of July 1, 2004 and will be renamed Standards and Guidelines. In addition, quality improvement activities have been

merged with the model's training requirements to improve quantity and quality of best practice standards. Best practice is based on the credentialing requirements of Prevent Child Abuse America – Healthy Families America with additional requirements built into the model by the program office, based in part, on the research evaluation findings of Johns Hopkins University. Further, federal compliance requirements, including HIPAA, FERPA, and 42 C.F.R. Part 2 have been implemented. Finally, the Child Health Early Intervention Record System (CHEIRS) has resulted in improved data collection.

HHS Training System

The training model is currently being aligned with the Quality Improvement System (QIS) to ensure that all trainings are specific to the Hawai'i Healthy Start program model and the Standards and Guidelines. In addition, research evaluation findings from Johns Hopkins have been taken into consideration. The goal is to improve both the continuity and quality of services by engaging POSP in more advanced trainings emphasizing skill development and utilization according to best practice.

The foundation of the State Training System is based on concepts from Adult Learning Theory. The theory is based on four assumptions about the characteristics of adult learners: self-concept, experience, readiness to learn, and motivation to learn. Adult Learning Theory engages the learner in doing and the learner helps direct their own learning. Utilizing this theory, trainings are being redesigned to be participatory in nature, query participants to engage in dialog, and help lead the learner to discover truths and knowledge for themselves.

Priorities:

- Utilization of community-based experts from the field.
- Identification and monitoring of program priority risk factors as a key outcome for every training.
- Experience in role-modeling and role-playing appropriate scenarios to develop/practice skill.
- Incorporating strategies from system change theory to increase effectiveness of training.
- Designing a protocol for position supervisors to follow-up and reaffirm skills after training.
- Implementation of a system for supervisors to track and plan training of staff.
- Integrating the Hawai'i Preschool Content Standards into the Healthy Start training model to increase the linkage with school readiness, and early childhood care and education initiatives.
- Developing a "train-the-trainer" component within the training model to support the in-state infrastructure. Covered issues will include: adult learning theory, adult learning styles, training diverse audiences (including parents), developing a trainers "tool box", and incorporating interactivity and mutual help into training and presentation styles.

A key theme is Infant Mental Health and evidence-based practice. By looking at the trainings as part of a state system rather than as individual sessions, the theme of developing and nurturing infant mental health will help integrate and coordinate the pieces together into an understanding of the model as well as the role and responsibility of each position and how each position works as an essential part of the team supporting the target child and family.

Other areas impacting the development of a State Training System are: 1). Growing training development demands that can not be meet by the POSP, who is charged with the delivery of the training system, and no full-time program staff person committed exclusively to training; 2). The monies allotted for training remaining constant while the demands for quality and quantity increase; and 3). Continuing staff turnover among the POSP

that results in a need for continued cycling through the foundations of training while also trying to advance the training model forward with more advanced participants.

A training strategic plan is currently under development to highlight system change and give appropriate deadlines. Given the demands of the system in relation to the supporting infrastructure, extended timelines for development and implementation are necessary.

HHS Standards for Quality Control

Healthy Start has instituted recommendations for quality control at the program level.
As of January 2004 MCHB strongly recommended that agency level home visiting policy and procedure be revised to include establishment of quality control measures complementary to fiscal responsibilities. All POSP were directed to develop a plan for implementing and monitoring chosen procedures, and to revise agency specific policy and procedure to incorporate established quality control measures and protocols. In addition, POSP were directed to train all staff in these areas.

All new employees receive orientation, including billing compliance, from their supervisor and this is documented in their personnel file.

Quality Improvement (QI) activities are documented in monthly supervisor team meetings, record notes, Clinical Supervision (CS) notes, and QI reports.

Methods of Quality Control – Program may select from the options below. Some of these may already be in place at a particular program. Agencies should determine which options are most suited for particular sites and incorporate into existing program policy and procedure. MCHB strongly recommends *a minimum of two items* be selected and implemented.

SHADOWING

1. Shadowing: Family Support Worker (FSW) and Family Assessment Worker (FAW) to learn of each other's roles – particularly for neighbor island sites or sites who hold both the Early Identification (EID) and Home Visiting (HV) contracts.
2. Clinical Supervisor (CS) shadowing of FSW: Every new family with FSW at first home visit.
3. CS shadowing of FSW: Every FSW once a quarter.
4. CS shadowing of FSW: Every family discharging, if there is advanced knowledge of discharge.
5. CS Supervisor: Once a quarter the supervisor of the Clinical Supervisor observes a supervision session with an FSW.

OUTREACH TO FAMILIES

1. CS sends a "welcome letter" to every new family encouraging contact within two weeks of admission.
2. Phone Survey: CS call 4 actively participating families per FSW per quarter
3. Phone Survey: CS call all Level X per FSW per quarter

DOCUMENTATION

1. Families sign off after every home visit and CS compares signature on original consent with signatures on billing sheets
2. CS match billing with HV notes to verify and sign off on log
3. Weekly supervision of FSW and CS. Group sessions are documented in meeting minutes.
4. Chart review: CS review 5 charts per month per FSW
5. Chart review: Supervisors of CS review supervision binders once a quarter

HHS Continuous Quality Improvement

On-going continuous quality improvement activities are implemented at three distinct levels within the Healthy Start program.

- **Individual Purchase of Service Program (POSP) Quality Assurance.** HFA credentialing is required of each Healthy Start POSP. This process includes areas of self-assessment, satisfaction surveys, and self-improvement strategies monitored in a quality improvement plan that is systematically reviewed by HFA. This ensures a level of quality in home visiting services not only across the state, but also on a nationally recognized level. Further, each POSP implements various quality assurance activities at an agency level that includes, but is not limited to, the Healthy Start program.

- **Program Quality Improvement.** Healthy Start has several reporting requirements designed to monitor quality assurance at each site/program. These include quarterly reports, bi-annual quality improvement reports, annual variance reports, and biennium contract evaluation reports. All of these reports provide continuing information on performance objectives. With oversight provided by the Quality Assurance Specialist, each site/program is specifically assigned to the Quality Assurance Specialist, the Registered Professional Nurse, or the Children & Youth Specialist. Typically, those sites/programs furthest from achieving performance objectives are assigned to the Quality Assurance Specialist who works with the site in developing specific quality improvement strategies with the provision of additional technical assistance. Each site/program is required to design, implement, monitor, and report on quality improvement activities to the respective administrative contact.

  Beginning in the new state fiscal year, July 1, 2004, all sites will be required to implement the Healthy Start Quality Improvement Plan which addresses program level areas of needed improvement, as prioritized by the Program Office, including but not limited to

  - Full compliance with stated timelines for IFSP completion;
  - Full compliance with stated timelines for developmental screens completion, referrals, and follow-up;
  - Increasing rates of prenatal enrollment;
  - Increasing completion rates of screens/assessments;
  - Increasing rates of referral to home visiting services;
  - Decreasing rates of Level X families (increasing engagement rates);
  - Increasing rates of retention of families; and,
  - Increasing transitioning planning/activities for target children exiting the program.

- **Model Quality Improvement**. Individual site/program information is synthesized and evaluated to identify areas of strength and areas requiring restructuring within the model by the Healthy Start administrative team. This level of policy analysis also includes program directors, the Family and Community Support Section Supervisor, the Maternal and Child Health Branch Chief, and the Family Health Service Division Chief. In addition, evaluation results from Johns Hopkins University, the principal outside research evaluator of Healthy Start, are analyzed with results influencing policy decisions.

  - Priority One: Full utilization of the Child Development Specialist.

    The role of the CDS is to support optimal child growth and development utilizing a variety of appropriate developmental screening tools and timely intervention strategies with families and Healthy Start staff. As such, this position is integral to the effective delivery of services for children with suspected developmental delays. Once the appropriate developmental screens are administered and reviewed, the CDS is responsible for timely referral of children to Early Intervention Services (EIS) for comprehensive professional evaluation, following the child through service and supporting the family, and guiding the family and Family Support Workers (FSW) on developmentally appropriate activities, via group activities and individual consultations, to enhance EIS. The CDS may also be involved in coordinating developmental services for a family should the evaluation deem those services necessary.

    Healthy Start requires one CDS per site. Healthy Start has a minimum total of 13 CDS positions statewide. Some agencies choose to support the CDS position beyond the contract requirements, given the numbers served at any one site. This is especially true for Oahu sites. At the end of March 2004, 11 of the 13 positions were filled. Three agencies/sites have more than one CDS. Thus, there were actually 15 CDS positions working within the Healthy Start model. Just one Oahu site had the two vacancies. However, the agency has one CDS position filled who is available to support the entire agency along with technical assistance provided MCHB. In addition, at the direction of MCHB, the agency has implemented a contingency plan to assure that service provided by other specialists until the position is filled. The agency is responsible for continuing recruitment efforts.

  - Priority Two: Development of a systemic training model

    The current training POSP is supporting MCHB is developing and implementing an enhanced system of training for Healthy Start based on in-state capacity to counter demand with supply. In addition, The Quality Assurance (QA) Specialist has been working closely with Healthy Families America and has been recognized as a State Leader. The purpose is to help increase model efficacy. In addition, the QA Specialist is on the advisory board of HFA's Western Regional Resource Center (WRRC). The WRRC has prioritized training and this collaboration benefits both Hawaii Healthy Start and HFA in the development of a systemtic training system related to home visiting programs aimed at the prevention of child abuse and neglect.

    Concurrent areas of development include:
    - A shift from delivery content alone to application based on best practice and HFA critical elements.
    - Integration of adult learning theory.

- Increased utilization of content area specific community resources.
- Implementation of a train-the-trainer model to increase trainer effectiveness.
- Transition from continuous cycle of Intensive Role Specific training to more advanced training, based, in part, in research evaluation findings shared by Johns Hopkins.
- Expansion of child development training by utilizing the Program for Infant/Toddler Caregivers (PITC), a comprehensive curriculum and training system for providers working with children under three years of age. PITC addresses both the need for a coherent curriculum that also builds on the child's innate motivation to learn.
- Development of a Healthy Start specific EIS orientation to comply with Office of Special Education Program (OSEP) requirements.

As a result, there are several areas where quality protocols are under development, with full implementation by the end of 2004. These areas are beyond HFA standards and are designed to further support the model for improved efficaciousness. Broader areas include creative outreach and supervision. More specific examples include:

- Accurate completion and timely, coordinated utilization of developmental screens and related follow-up.

- The Healthy Start Nurse, in conjunction with the Quality Assurance Specialist, has developed and implemented a systemic system for quality control monitoring of children with suspected developmental delays. Numbers will be tracked and trends will be analyzed, including a breakdown by developmental domain. This information will be used to establish baseline date, focus on improved outcomes, identify sites needing technical assistance, and to recognize additional training needs. Further, after review of individual referrals, the Healthy Start Nurse follows-up with specific sites to assure quality and timeliness of service.

- Streamlining and improving documentation of key Healthy Start program components.

- Identifying and implementing a pre-natal curriculum as well as a child development curriculum for use across the state Healthy Start system. These curricula will be enhanced to focus on the natural environment, the importance of fathers in a child's life, structured parent-child interaction (observation and feedback, use of video camera), and life planning (including family planning)/goal attainment.

- Enhancing the parent involvement component. HFA has a promising new model and organization for parent involvement called Circle of Parents.

- Revising the Level Movement System and developing corresponding, supporting documentation (for example, based on the work of Margaret Ainsworth).

- Increasing the emphasis on Family Violence Prevention by working across programs within MCHB to coordinate services, standards, and screening protocols for all POSP.

Early Intervention System Quality Assurance

In partnership with the Early Intervention Section, Children with Special Health Needs Branch, Healthy Start modified existing quality assurance activities to fully reflect the EIS approach in conforming with federal IDEA Part C and state requirements to assure that all environmentally at-risk children age 0-3 years and their families are provided, through a family-centered, community-based, culturally sensitive, coordinated process, the necessary early intervention services to meet their needs.

As Healthy Start records are covered under the Family Education Record Act (FERPA), the corresponding document legislation to IDEA, Part C, Healthy Start has worked with Early Intervention Section to develop and implement a compliance plan.

- Disseminate the Family Rights brochure to all new Healthy Start families.
  This policy was fully implemented by all Healthy Start programs in fall 2003.

- Incorporate the Family Rights brochure into all pertinent documentation for new families (consents, notices, authorizations, etc.), i.e., family has received it, reviewed it, understood it, had an opportunity to ask questions, knows whom to contact with a complaint, etc.

- Review and disseminate the Family Rights brochure again during each annual Individual Family Support Plan (IFSP).

- Develop a system with EIS to provide OSEP training to all staff (this began in January 2004 and is on-going).

Healthy Start administrative staff engage in on-site monitoring.

- **On-Site Monitoring of Program, Contractual & IDEA, Part C Requirements**. The Healthy Start administrative team conducts on-site monitoring of the first contract year during the second quarter of the second contract year for all sites. Programs respond to the monitoring report of Findings and Recommendations via a quality improvement plan that specifically addresses the monitoring results. Sites requiring significant improvement are monitored again six to nine months later to ascertain degree of improvement.

  Healthy Start systematically requires the following standardized reports that are reviewed and analyzed for quality assurance purposes.

  - Quarterly Reports (due no later than 30 days from the close of the quarter);
  - Biannual Home Visiting Quality Improvement Reports (due no later than 30 days from the close of the period);
  - Annual Variance Reports (due no later than 60 days from the close of the state contract year);
  - Contract Evaluation Reports (due no later than 90 days from the close of the two year contract period);
  - Monthly Felix Reports (due no later than the second Monday after the close of a month).

  Continuing POSP reporting challenges are provided technical assistance with specific recommendations for improvement. This information is then used to inform specific monitoring

activities described below. Areas that have do not show improvement is specifically followed-up on in the monitoring process.

Monitoring includes:

- Program & Contractual Requirements. Contract performance objectives are reviewed as are adherence to specialist models. Each agency's policies and procedures are reviewed to evaluate whether they are consistent with program and contractual requirements as well as federal standards (e.g., Occupational Health and Safety Administration standards, American with Disabilities Act, drug-free policies, etc.). Quality control protocols are reviewed. A sample of personnel records and security/storage protocol of confidential information are reviewed.

Monitoring of IDEA, Part C requirements began in the third quarter of FY 2004, as Healthy Start is a provider to the Early Intervention Section, lead agency in the state's Early Intervention System.

- IDEA, Part C Requirements. A sample of child charts are evaluated on a variety of indicators including: meeting IDEA timelines; inclusion of evaluation reports, complete IFSPs, consents, transition activities, progress/anecdotal notes in each chart; and confirmation that information on procedural safeguards was provided to each family. IFSPs are reviewed utilizing a checklist developed by the community Office of Special Education Programs (OSEP) IFSP Workgroup to ensure that they include all required components, including a transition plan if appropriate and completion of transition activities. In addition to the chart review, an "IDEA Requirements Checklist" is completed to determine if programs have policies and procedures consistent with IDEA Part C.

Programs are in the process of completing their Improvement Plans based on the results cited in the monitoring reports. Priorities include timely completion of all IFSPs and developmental screens as well as full implementation of the Child Development Specialist model in which this specialist has the most interaction with referrals of children with suspected developmental delays and follow-up to EIS. Once completed, EIS will review and approve the plan, with each program having one year to complete the improvement outcomes identified in the plan. In conjunction with technical assistance from Healthy Start program staff, EIS staff is available to provide training and support to the public and private early intervention programs to reach their goals.

Need for Community Support and Collaboration

There are several areas within or related to the Healthy Start Model that could definitely support and strength home visiting services and the prevention of child maltreatment/family violence across the state. These include:

- Annual conference
- Research $\Rightarrow$ practice
- Strong partnership with PCA HI Network building
- Strategic planning
- PR, marketing (website), advocacy
- Collaboration building and improved communication with OB-GYN and PED (medical home)
- Leadership training

Attachment D

Healthy Families America Critical Elements

HEALTHY FAMILIES AMERICA
Critical Elements

1. Initiate services prenatally or at birth.

2. Use a standardized (i.e., in a consistent way for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e., social isolation, substance abuse, parental history of abuse in childhood).

3. Offer services voluntarily and use positive, persistent outreach efforts to build family trust.

4. Offer services intensely (i.e., at least once a week) with well-defined criteria for increasing or decreasing intensity of service and over the long term (i.e., three to five years).

5. Services should be culturally competent such that staff understands, acknowledges, and respects cultural differences among participants: staff and materials used should reflect the cultural linguistic, geographic, racial and ethnic diversity of the population served.

6. Services should focus on supporting the parent(s) as well as supporting parent-child interaction and child development.

7. At a minimum, all families should be linked to a medical provider to assure optimal health and development (i.e., timely immunizations, well-child care, etc.). Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.

8. Services should be provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities (i.e., for many communities, no more than fifteen (15) families per home visitor on the most intense service level. And, for some communities, the number may need to be significantly lower, i.e., less than ten (10).

9. Service providers should be selected because of their personal characteristics (i.e., non-judgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.

10a. Service providers should have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at risk families. All service providers should receive basic training in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community.

10b Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation (i.e., identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunizations, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing an individual family support plan, observing parent-child interactions, determining the safety of the home, teaching parent-child interaction, managing crisis situation, etc.).

11. Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference and in order to avoid stress-related burnout.

HFA Critical Elements

These should already be part of your QIP and are incorporated into HHS Quarterly and Semi-Annual Reports.

EID

1-1.D. 95% -100% of eligibility screen/assessment occurs either prenatally or within the first 2 weeks after the birth of the baby.

1-2-A. The program defines, measures, and monitors the acceptance rate of participants into the program and evidence indicates acceptance rates are being measured more than once a year [HHS EID Quarterly Report].

1-2-B. The program semi-annually [HHS semi-annual QIP report] uses both formal and informal methods to analyze who refused the program and why. This analysis addresses programmatic, demographic, social, and other factors.

HV

3-2-A. The program has clearly written, comprehensive guidelines that specify a variety of positive outreach methods (e.g., telephone calls, visits, mailings, parenting groups, etc.).

3-3-A. The program guidelines specify the circumstances under which a participant is placed in outreach status.

3-4-A. The program defines, measures, and monitors the retention rates of participants in the program and evidence indicates retention rates are being measured more than once a year [HHS HV Quarterly Report].

3-4-B. The program semi-annually uses both formal and informal methods to analyze who leaves the program and why. This analysis addresses programmatic, demographic, social, and other factors [HHS Semi-Annual QIP Report].

3-4-C. The program addresses how it might increase its retention rate based on its analysis of programmatic, demographic, social, and other factors related to dropping out of the program after receiving services. Based on this analysis, the program has implemented a plan for increasing its retention rate among the individuals who are currently dropping out of the program. The plan addresses programmatic, demographic, social, and other factors.

4-1-C. The program analyses and addresses how it might increase its home visitation completion rate. Based on this analysis, the program has implemented a plan for increasing its home visitation completion rate.

4-1-E. The program regularly reviews progress made by participants, and involves, at a minimum, the home visitor, the participant, and the supervisor in this process.

4-2-A. Policy states that participants receiving intensive home visitation services are offered weekly home visits for a minimum of 6 months after the birth of the baby.

Training / Cultural Competency

5-3 The program provides staff training [all staff annually] on culturally competent practices based on the unique characteristics of the population(s) being served, I.e., age related factors, language, culture, etc.) by the program.

5-4 The program regularly evaluates the extent to which all aspects of its service delivery system (i.e., family assessment, service planning, home visitation, supervision, etc.) are culturally competent.

5-4-A. There is an annual review of cultural competency that addresses the following components: materials, training, and service delivery system.

5-4-B. The annual review of culturally competent practices includes participants input regarding culturally appropriate services.

5-4-C. The annual review of culturally competency practices includes staff input regarding culturally appropriate services.

5-4-D. The review is reported at least annually to the appropriate supervisory of advisory/governance group.

5-4-E. The appropriate supervisory or advisory/governance group takes action on the recommendations contained within the report.

Training / Requirements

10-1-A. The program has a training plan that assures access to required trainings in a timely manner for all staff.

10-1-B. The program has a system to monitor staff training.

Use of Screen/Assessment Information

6-1-A. Based on the program's written guidelines, the CS and the HV consistently address and review the issues identified by the participant in the initial assessment.

6-1-B. Based on the program's written guidelines, the HV addresses and reviews issues identified in the initial assessment with the participant.

CDS

6-7-A. The program has guidelines which address how it tracks and follows through with appropriate actions for child participants suspected of having a developmental delay.

6-7-B. The program routinely tracks target children suspected of having a developmental delay.

6-7-C. The program routinely follows through with appropriate actions (i.e., referrals, in-depth evaluations or examinations, treatment or other services.

All Services, including CSp (in our program)

7-3 Participants are linked to additional services on an as-needed basis taking into account one or more of the following: information gathered in the assessment process, through the development of the IFSP, through home visits, from other service providers, etc.

7-3-A. The program connects participants to appropriate referral sources and services in the community based upon the information gathered.

7-3-B. The program follows up with the referral source, service provider, and/or participant to determine if the participant received needed services.

Caseload

8-1-A. Caseload is limited to no more than 15 Level I.
8-1-B. Caseload should not exceed 25 (at any combination of service levels).

Supervision

8-2-A. There are guidelines for managing caseloads.
8-2-B. The program uses the guidelines to manage caseloads, including (but not limited to)

- Experience and skill level of the HV assigned
- Nature and difficulty of the problems

Attachment E

Table A
Performance Measures

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
There shall be no confirmed report of Child Abuse and/or Neglect (CAN) for families enrolled in the program at least twelve (12) months.	**a) Number of at-risk children and their families enrolled for at least 12 months was _____.** **b) Number of at-risk children and their families enrolled for at least 12 months, who did not have a confirmed report of CAN was _____.** **c) Percent of at-risk children and their families enrolled for at least 12 months, who did not have a confirmed report of CAN was _____. (b divided by a).**	**100 percent of all at- risk children and their families enrolled in the program for at least 12 months shall not have a confirmed report for CAN.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
There shall be no re-occurrence of CAN for Child Welfare Services (CWS) and CWS Diversion families receiving Healthy Start Services.	**a) Number of CWS and CWS Diversion families receiving Healthy Start services was _____.** **b) Number of CWS and CWS Diversion families receiving Healthy Start services, who did not have a re-occurrence of CAN was _____.** **c) Percent of CWS and CWS Diversion families receiving Healthy Start services, who did not have a re-occurrence of CAN was _____. (b divided by a).**	**100 percent of all CWS and CWS Diversion families receiving Healthy Start services shall not have a re-occurrence of CAN.**	

Table A – Performance Measures

Applicant Org.

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Pregnant women engaged prenatally will continue with Home Visiting services after the birth of their infant.	**a) Number of pregnant women engaged prenatally _____.** **b) Number of pregnant women who continued with Home Visiting Services after the birth of their infant was _____.** **c) Percent of pregnant women who continued with Home Visiting services after the birth of their infant was _____. (b divided by a).**	**100 percent of pregnant women engaged prenatally will continue with Home Visiting services after the birth of their infant.**	

Table A – Performance Measures

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Enrolled women with a subsequent pregnancy shall receive prenatal care within thirty (30) days after pregnancy is made known to the AWARDEE.	**a) Number of enrolled women with a subsequent pregnancy was _____ .** **b) Number of enrolled women with a subsequent pregnancy who received prenatal care within 30 days after pregnancy was made known to the AWARDEE was _____.** **c) Percent of enrolled women with a subsequent pregnancy who did receive prenatal care within 30 days after pregnancy was made known to the AWARDEE was _____.** **b divided by a).**	**100 percent of enrolled women with a subsequent pregnancy shall receive prenatal care within 30 days after pregnancy is made known to the AWARDEE.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Develop and implement an Individualized Family Support Plan (IFSP) for each target child within forty-five (45) days following identification of eligibility for Healthy Start (HS) Home Visiting (HV) services.	**a) Number of target children requiring an IFSP within 45 days following identification of eligibility for HS HV services was _____.** **b) Number of target children who completed an IFSP within 45 days following identification of eligibility for HS HV services was _____.** **c) Percent of target children who completed an IFSP within 45 days following identification of eligibility for HS HV services was _____. (b divided by a).**	**100 percent of target children shall have a completed Individualized Family Support Plan (IFSP) done within 45 days following identification of eligibility for Healthy Start (HS) Home Visiting (HV) services.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
The Individualized Family Support Plan (IFSP) shall be reviewed at a minimum of six (6) months intervals from the day and month of the initial IFSP for each target child.	**a) Number of target children requiring an IFSP review at 6 months from the day and month of the initial IFSP was _____.** **b) Number of target children who completed an IFSP review at 6 months from the day and month of the initial IFSP was _____.** **c) Percent of target children who completed an IFSP review at 6 months from the day and month of the initial IFSP was _____.** **(b divided by a).**	**100 percent of target children shall have their IFSP reviewed at a minimum of 6 months from the day and month of the initial IFSP.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
A new, updated Individualized Family Support Plan (IFSP) will be completed annually (each and every year from day and month of the initial IFSP) for each target child.	**a) Number of target children requiring a new updated annual IFSP from the day and month of the initial IFSP was _____.** **b) Number of target children who completed a new annual IFSP from the day and month of the initial IFSP was _____.** **c) Percent of target children who completed a new updated annual IFSP from the day and month of the initial IFSP was _____.** **(b divided by a).**	**100 percent of target children shall have a new, updated annual IFSP from the day and month of the initial IFSP.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Target children and their families enrolled in the program shall have an identified medical home for well and sick care.	**a) Number of target children and their families enrolled in the program was _____.** **b) Number of target children and their families with an identified medical home for well and sick care was _____.** **c) Percent of target children and their families that have an identified medical home for well and sick care was _____.** **b divided by a)**	**100 percent of target children and their families enrolled in the program shall have an identified medical home for well and sick care.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Enrolled target children at two (2) years of age shall be fully immunized.	**a) Number of enrolled target children at age two was _____.** **b) Number of enrolled target children at age two who were fully immunized was _____.** **c) Percent of enrolled target children at age two who were fully immunized was _____.** **(b divided by a).**	**100 percent of enrolled target children at two (2) years of age shall be fully immunized.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Target children and their families enrolled in the program shall have an identified dental home for recommended dental care.	**a) Number of target children and their families enrolled in the program was _____.** **b) Number of target children and their families with an identified dental home was _____.** **c) Percent of target children and their families that have an identified dental home was _____.** **(b divided by a).**	**100 percent of target children and their families enrolled in the program shall have an identified dental home for recommended dental care.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Enrolled target children at two (2) years of age shall have an oral examination by a dentist.	**a) Number of enrolled target children at two years of age was _____.** **b) Number of enrolled target children at two years of age who have received a dental examination by a dentist was _____.** **c) Percent of enrolled target children at two years of age who have received a dental examination was _____. (b divided by a).**	**90 percent of enrolled target children at two years of age shall have a dental examination by a dentist.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Target children shall have a documented attachment scale approved by Maternal and Child Health Branch (MCHB), such as the Home Observation for Measurement of the Environment (HOME) scale, at approximately six (6) months of age.	**a) Number of target children enrolled in the program that should have a documented HOME scale at approximately 6 months of age was _____.** **b) Number of target children enrolled in the program that have a documented HOME scale at approximately 6 months of age was_____.** **c) Percent of target children enrolled in the program that have a documented HOME scale at approximately 6 months of age was_____. (b divided by a).**	**90 percent of target children who become six (6) months of age within the fiscal year shall have a documented attachment scale approved by Maternal and Child Health Branch (MCHB), such as the Home Observation for Measurement of the Environment (HOME) scale.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Target children who become six (6) and eighteen (18) months of age (183 and 548 days respectively) within the fiscal year, who had a Family Stress Checklist score of forty (40) or higher and/or the HOME score of thirty-two (32) or below, shall receive a documented Nursing Child Assessment Satellite Training (NCAST) Teaching scale.	**a) Number of target children who became 6 months of age within the fiscal year, who had a Family Stress Checklist score of 40 or higher and/or the HOME score was 32 or below that needed to have an NCAST Teaching scale conducted at approximately 6 months of age was _____.** ***Number of target children who became 18 months within the fiscal year who had a Family Stress Checklist score of 40 or higher and/or the HOME score was 32 or below that needed to have an NCAST Teaching scale conducted at approximately 18 months of age was _____.*** ***b) Number of target children who became 6 months of age within the fiscal year who had a Family Stress Checklist score of 40 or higher and/or the HOME score was 32 or below that had an NCAST Teaching scale conducted at approximately 6 months of age was _____.*** **Number of target children who became 18 months of age within the fiscal year who had a Family Stress Checklist score of 40 or higher and/or the HOME score was 32 or below that had an NCAST Teaching scale conducted at approximately 18 months of age was _____.**	***90 percent of eligible target children who become six (6) and eighteen (18) months of age (183 and 548 days respectively) within the fiscal year, who had a Family Stress Checklist score of forty (40) or higher and/or the HOME score is thirty-two (32) or below, shall receive a documented Nursing Child Assessment Satellite Training (NCAST) Teaching scale.***	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Target children who become six (6) and eighteen (18) months of age (183 and 548 days respectively) within the fiscal year, who had a Family Stress Checklist score of forty (40) or higher and/or the HOME score of thirty-two (32) or below, shall receive a documented Nursing Child Assessment Satellite Training (NCAST) Teaching scale. **(Cont'd)**	***c) Percent of target children who became 6 months of age within the fiscal year who had a Family Checklist score of 40 or higher and/or the HOME score was 32 or below that had an NCAST Teaching scale conducted at approximately 6 months of age was _____.*** ***Percent of target children who became 18 months within the fiscal year who had a Family Stress Checklist score of 40 or higher and/or the HOME score was 32 or below that had an NCAST Teaching scale conducted at approximately 18 months of age was _____.*** **(b divided by a).**	***90 percent of eligible target children who become six (6) and eighteen (18) months of age (183 and 548 days respectively) within the fiscal year, who had a Family Stress Checklist score of forty (40) or higher and/or the HOME score is thirty-two (32) or below, shall receive a documented Nursing Child Assessment Satellite Training (NCAST) Teaching scale.*** ***(Cont'd)***	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Target children without a confirmed developmental delay, shall have a documented Ages and Stages Questionnaire (ASQ) done within the window period at four (4), twelve (12), sixteen (16), twenty-four (24), thirty (30), thirty-six (36), forty-two (42), forty-eight (48), fifty-four (54), and sixty (60) months of age. ** **** A variance shall be reported for each individual screening period.**	**a) Number of target children without a confirmed developmental delay, requiring a documented ASQ at 4, 12, 16, 24, 30, 36, 42, 48, 54, and 60 months was _____.** **b) Number of target children without a confirmed developmental delay, that had a documented ASQ done within the window period at 4, 12, 16, 24, 30, 36, 42, 48, 54, and 60 months was _____.** **c) Percent of target children without a confirmed developmental delay, that had a documented ASQ done within the window period at 4, 12, 16, 24, 30, 36, 42, 48, 54, and 60 months was _____. (b divided by a).**	**100 percent of target children without a confirmed developmental delay, shall have a documented Ages and Stages Questionnaire (ASQ) done within the window period at four (4), twelve (12), sixteen (16), twenty-four (24), thirty (30), thirty-six (36), forty-two (42), forty-eight (48), fifty-four (54), and sixty (60) months of age.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Target children shall have a documented Ages and Stages Questionnaire – Social Emotional (ASQ-SE) done within the window period at six (6), twelve (12), eighteen (18), twenty-four (24), thirty (30), thirty-six (36), and forty-eight (48) months of age. ** **** A variance shall be reported for each individual screening period.**	**a) Number of target children requiring a documented ASQ-Se at 6, 12, 18, 24, 30, 36, and 48 months was _____.** **b) Number of target children that had a documented ASQ-SE done within the window period at 6, 12, 18, 24, 30, 36, and 48 months was _____.** **c) Percent of target children that had a documented ASQ-SE done within the window period at 6, 12, 18, 24, 30, 36, and 48 months was _____. (b divided by a).**	**100 percent of target children shall have a documented Ages and Stages Questionnaire – Social Emotional (ASQ-SE) done within the window period at six (6), twelve (12), eighteen (18), twenty-four (24), thirty (30), thirty-six (36), and forty-eight (48) months of age.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Enrolled families participating in the program shall receive family planning information.	**a) Number of enrolled families participating in the program was _____.** **b) Number of enrolled families participating in the program that did receive family planning information was _____.** **c) Percent of enrolled families participating in the program that did receive family planning information was _____. (b divided by a).**	**90 percent of enrolled families participating in the program shall receive family planning information.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Malleable risk factors for families on Level III shall be reduced prior to movement to Level IV, as measured by a post test specified by the DEPARTMENT, such as a score of twenty-five (25) and below on items 4, 5, 6, and 8 of the Family Stress Checklist (Kemp, 1972).	**a) Number of program families promoted to a Level IV was _____.** **b) Number of program families promoted to a Level IV that had changeable risk factors reduced to twenty-five (25) and below on items 4, 5, 6, and 8 of the Family Stress Checklist (Kemp, 1972) was _____.** **c) Percent of program families promoted to a Level IV that had malleable risk factors reduced, such as a score of twenty-five (25) and below on items 4, 5, 6, and 8 of the Family Stress Checklist (Kemp, 1972) was _____. (b divided by a)**	**90 percent of program families promoted to Level IV shall have malleable risk factors reduced, as measured by a post test specified by the DEPARTMENT, such as a score of twenty-five (25) and below on items 4, 5, 6, and 8 of the Family Stress Checklist (Kemp, 1972).**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

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Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All new Family Support Workers (FSW) shall complete Healthy Families America (HFA)/Maternal and Child Health Branch (MCHB) Intensive Role-Specific (IRS) training at the first available training offered and not later than six (6) months of hire.	**a) Number of new FSWs employed by the program was _____.** **b) Number of new FSWs that completed HFA/MCHB IRS training within six months of hire was _____.** **c) Percent of new FSWs that completed HFA/MCHB IRS within six months of hire was _____.** **(b divided by a).**	**100 percent of new FSW shall complete HFA/MCHB IRS training within six months of hire.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

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Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All new Clinical Supervisors (CS) shall complete Healthy Families America (HFA)/Maternal and Child Health Branch (MCHB) Intensive Role Specific (IRS) training at the first available training offered and no later than six months of hire.	**a) Number of new CSs employed by the program was _____.** **b) Number of new CSs that completed HFA/MCHB IRS training within six months of hire was _____.** **c) Percent of new CSs that completed HFA/MCHB IRS training within six months of hire was _____.** **(b divided by a).**	**100 percent of new CSs shall complete HFA/MCHB IRS training within six months of hire.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All new Child Development Specialists (CDS) shall complete Healthy Families America (HFA)/Maternal and Child Health Branch (MCHB) Intense Role Specific (IRS) training at the first available training offered and no later than six months of hire.	**a) Number of new CDSs employed by the program was _____.** **b) Number of new CDSs who completed HFA/MCHB IRS training within six months of hire was _____.** **c) Percent of new CDSs who completed HFA/MCHB IRS training within six months of hire was _____.** **(b divided by a).**	**100 percent of new CDSs shall complete HFA/MCHB IRS training within six months of hire.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All new Clinical Specialists (CSp) shall complete Healthy Family America (HFA)/Maternal and Child Health Branch (MCHB) Intensive Role Specific (IRS) training at the first available training offered and no later than six months of hire.	**a) Number of new CSps employed by the program was _____.** **b) Number of new CSps who completed HFA/MCHB IRS training within six months of hire was _____.** **c) Percent of new CSps who completed HFA/MCHB IRS training within six months of hire was _____.** **(b divided by a).**	**100 percent of new CSps shall complete HFA/MCHB IRS training within six months of hire.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All new Family Support Workers (FSW) hired prior to July 1, 2002 shall complete Healthy Family America (HFA)/Maternal and Child Health Branch (MCHB) Intense Role Specific (IRS) training by the end of the first contract year.	**a) Number of FSWs hired prior to July 1, 2002 was _____.** **b) Number of FSWs that completed HFA/MCHB IRS training by June 30, 2006 was _____.** **c) Percent of FSWs that completed HFA/MCHB IRS training by June 30, 2006 was _____.** **(b divided by a).**	**100 percent of FSWs hired prior to July 1, 2002 shall complete HFA/MCHB IRS training by June 30, 2006.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All new Family Support Workers (FSW) shall complete additional Healthy Families America (HFA)Maternal and Child Health Branch (MCHB) training within six months of hire.	**a) Number of new FSW employed by the program was _____.** **b) Number of new FSW that completed additional HFA/MCHB training within six months of hire was _____.** **c) Percent of new FSW that completed additional HFA/MCHB training within six months of hire was _____. (b divided by a).**	**100 percent of new FSW shall complete additional HFA/MCHB training within six months of hire.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All new Clinical Supervisors (CS) shall complete additional Healthy Families America (HFA)/Maternal and Child Health Branch (MCHB) training on case management and reflective supervision within six months of hire.	**a) Number of new CS employed by the program was _____.** **b) Number of new CS that completed additional HFA/MCHB training on case management and reflective supervision within six months of hire was _____.** **c) Percent of new CS that completed additional HFA/MCHB training on case management and reflective supervision within six months of hire was _____.** **(b divided by a).**	**100 percent of new CS shall complete additional HFA/MCHB training on case management and reflective supervision within six months of hire.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All new Home Visiting staff (Family Support Workers, Clinical Supervisors, Child Development Specialists, and Clinical Specialists) shall complete Healthy Families America (HFA)/Maternal and Child Health Branch (MCHB) determined continuous training on a variety of topics necessary for effectively working with families and children within 12 months of hire.	**a) Number of new Home Visiting staff employed by the program was _____.** **b) Number of new Home Visiting staff that completed HFA/MCHB determined continuous training on a variety of topics necessary for effectively working with families and children within 12 months of hire was _____.** **c) Percent of new Home Visiting staff that completed HFA/MCHB determined continuous training on a variety of topics necessary for effectively working with families and children within 12 months of hire was _____. (b divided by a).**	**100 percent of new Home Visiting staff (Family Support Workers, Supervisors, Child Development Specialists, and Clinical Specialists) shall complete HFA/MCHB determined continuous training on a variety of topics necessary for effectively working with families and children within 12 months of hire.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All Home Visiting staff (Family Support Workers, Supervisors, Child Development Specialists, Clinical Specialists, Directors, and Executive Directors) shall complete Healthy Families America (HFA)/Maternal and Child Health Branch (MCHB) determined continuous training on a variety of topics necessary for effectively working with families and children in each subsequent year of employment.	**a) Number of Home Visiting staff employed by the program was _____.** **b) Number of Home Visiting staff that completed HFA/MCHB determined continuous on a variety of topics necessary for effectively working with families and children in each subsequent year of employment was _____.** **c) Percent of Home Visiting staff that completed HFA/MCHB determined continuous training on a variety of topics necessary for effectively working with families and children in each subsequent year of employment was _____. (b divided by a).**	**100 percent of Home Visiting staff (Family Support Workers, Supervisors, Child Development Specialists, Clinical Specialists, Directors, and Executive Directors) shall complete HFA/MCHB determined continuous training on a variety of topics necessary for effectively working with families and children in each subsequent year of employment.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All Home Visiting Supervisors shall receive Healthy Families America (HFA)/Maternal and Child Health Branch (MCHB) advanced training on case management and clinical supervision within 12 months of hire.	**a) Number of Home Visiting Supervisors employed by the program was _____.** **b) Number of Home Visiting Supervisors that received HFA/MCHB advanced training on case management and clinical supervision within12 months of hire was _____.** **c) Percent of Home Visiting Supervisors that received HFA/MCHB advanced training on case management and clinical supervision within 12 months of hire was _____. (b divided by a).**	**100 percent of Home Visiting Supervisors shall receive HFA/MCHB advanced training on case management and clinical supervision within 12 months of hire.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
All Home Visiting Supervisors shall receive Healthy Families America (HFA)/Maternal and Child Health Branch (MCHB) advanced training on case management and clinical supervision in each subsequent year of employment.	**a) Number of Home Visiting Supervisors employed by the program was _____.** **b) Number of Home Visiting Supervisors that received HFA/MCHB advanced training on case management and clinical supervision in each subsequent year of employment was _____.** **c) Percent of Home Visiting Supervisors that received HFA/MCHB advanced training on case management and clinical supervision in each subsequent year of employment was ____. (b divided by a).**	**100 percent of Home Visiting Supervisors shall receive HFA/MCHB advanced training on case management and clinical supervision in each subsequent year of employment.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Target children who score one (1) standard deviation on the Ages and Stages Questionnaire (ASQ) shall be referred to the Child Development Specialist (CDS) for follow up.	**a) Number of target children who scored a one (1) standard deviation on the ASQ was _____.** **b) Number of target children who scored a one (1) standard deviation on the ASQ and was referred for follow-up was _____.** **c) Percent of target children who scored a one (1) standard deviation on the ASQ and was referred for follow-up was _____.** **(b divided by a)**	**Ninety-five percent of target children who score 1 standard deviations on the Ages and Stages Questionnaire (ASQ) shall be referred to the Child Development Specialist (CDS) for follow-up.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Target children who score two (2) standard deviations on the Ages and Stages Questionnaire (ASQ) shall be referred to the Child Development Specialist (CDS) for follow up.	**a) Number of target children who scored two (2) standard deviation on the ASQ was _____.** **b) Number of target children who scored two (2) standard deviation on the ASQ and was referred for follow-up was _____.** **c) Percent of target children who scored two (2) standard deviation on the ASQ and was referred for follow-up was _____.** **(b divided by a)**	**100 percent of target children who score two (2) standard deviations on the Ages and Stages Questionnaire (ASQ) shall be referred to the Child Development Specialist (CDS) for follow-up.**	

Table A – Performance Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C	Column D
Performance Measures	**Baseline for FY 2004**	**Annual Performance Objective for Fiscal Years 2005-2009**	**Explanation required if column B is not the same percentage as indicated in column C. POSP specific strategies to improve performance measure must include timeline and responsible persons. (Attach additional sheets as necessary).**
Target children who scored above the cut off score on a documented Ages and Stages Questionnaire – Social Emotional (ASQ-SE), shall be referred to the Child Development Specialist for follow-up.	**a) Number of target children who scored above the cut off on a documented ASQ-SE was _____.** **b) Number of target children who scored above the cut off score on a documented ASQ-SE and were referred to the Child Development Specialist for follow-up was _____.** **c) Percent of target children who scored above the cut off on a documented ASQ-SE and were referred to the Child Development Specialist for follow-up was _____.** **(b divided by a)**	**100 percent of target children who scored above the cut off score on a documented ASQ-SE, shall be referred to the Child Development Specialist for follow-up.**	

Attachment F

Table B
Output Measures

Table B – Output Measures

Applicant Org.
RFP No. HTH 550-3

Column A	Column B	Column C
Program Activity	**Annual Performance Objective for Fiscal Years 2005-2009**	**Applicant's approach in meeting the output objectives, including the methodology proposed for data collection and reporting. (Attach additional sheets as necessary.)**
Number of child development screening tools and parent-child interaction scales that were administered by the Child Development Specialist, Family Support Workers, and Others:		
Child Development Specialists:		
ASQ		
ASQ-SE		
Home Scales		
Teach Scales		
Family Support Workers:		
ASQ		
ASQ-SE		
Home Scales		
Teach Scales		
Others, please list (Attach additional pages as necessary):		

Table B – Output Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C
Program Activity	**Annual Performance Objective for Fiscal Years 2005-2009**	**Applicant's approach in meeting the output objectives, including the methodology proposed for data collection and reporting. (Attach additional sheets as necessary.)**
Number of referrals for evaluation based on the Ages and Stages Questionnaire (ASQ), made to Private Medical Doctors (PMD), Infant Toddler Development Centers, Preschools, Headstart, Department of Education (DOE), and other programs or specialists.		
PMD		
Early Childhood Services Program		
Preschools		
Headstart		
DOE		
Other programs or specialists, please list (Attach additional pages as necessary):		

Table B – Output Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C
Program Activity	**Annual Performance Objective for Fiscal Years 2005-2009**	**Applicant's approach in meeting the output objectives, including the methodology proposed for data collection and reporting. (Attach additional sheets as necessary.)**
Number of referrals for evaluation based on the Ages & Stages Questionnaire-Social Emotional made to Private Medical Doctors (PMD), Children-Adolescent Mental Health Division (CAMHD), Early Intervention Section (EIS), and other programs or specialists.		
PMD		
CAMHD		
EIS		
Others, please list. (Attach additional pages as necessary)		

Table B – Output Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C
Program Activity	**Annual Performance Objective for Fiscal Years 2005-2009**	**Applicant's approach in meeting the output objectives, including the methodology proposed for data collection and reporting. (Attach additional sheets as necessary.)**
Number of trainings conducted to Healthy Start Program Staff and Families (Group or individual families) during the fiscal year covering the topics of child development: (minimum one training per quarter)		
Healthy Start Program Staff		
Families		
Others, please list. (Attach additional pages as necessary)		

Table B – Output Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C
Program Activity	**Annual Performance Objective for Fiscal Years 2005-2009**	**Applicant's approach in meeting the output objectives, including the methodology proposed for data collection and reporting. (Attach additional sheets as necessary.)**
Number of referrals for Clinical Specialist services for:		
Substance Use/Abuse (including smoking)		
Family Violence (including intimate partner abuse)		
Mental Health Issues (e.g. symptoms of maternal depression)		
Others, please list. (Attach additional pages as necessary)		

Table B – Output Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C
Program Activity	**Annual Performance Objective for Fiscal Years 2005-2009**	**Applicant's approach in meeting the output objectives, including the methodology proposed for data collection and reporting. (Attach additional sheets as necessary.)**
Number of referrals to Clinical Specialist for treatment readiness services for:		
Substance Use/Abuse (including smoking)		
Family Violence (including intimate partner abuse)		
Mental Health Issues (e.g. symptoms of maternal depression)		
Others, please list. (Attach additional pages as necessary)		

Table B – Output Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C
Program Activity	**Annual Performance Objective for Fiscal Years 2005-2009**	**Applicant's approach in meeting the output objectives, including the methodology proposed for data collection and reporting. (Attach additional sheets as necessary.)**
Number of referrals made by the Clinical Specialist to outside agencies and programs, with documented follow-up, for treatment services involving:		
Substance Use/Abuse (including smoking)		
Family Violence (including intimate partner abuse)		
Mental Health Issues (e.g. symptoms of maternal depression)		
Others, please list. (Attach additional pages as necessary)		

Table B – Output Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C
Program Activity	**Annual Performance Objective for Fiscal Years 2005-2009**	**Applicant's approach in meeting the output objectives, including the methodology proposed for data collection and reporting. (Attach additional sheets as necessary.)**
Number of clients actually receiving treatment services from agencies and programs referred to by the Clinical Specialist involving:		
Substance Use/Abuse (including smoking)		
Family Violence (including intimate partner abuse)		
Mental Health Issues (e.g. symptoms of maternal depression)		
Others, please list. (Attach additional pages as necessary)		

Table B – Output Measures

Applicant Org.

RFP No. HTH 550-3

Column A	Column B	Column C
Program Activity	**Annual Performance Objective for Fiscal Years 2005-2009**	**Applicant's approach in meeting the output objectives, including the methodology proposed for data collection and reporting. (Attach additional sheets as necessary.)**
Number of trainings provided to the Healthy Start Program staff during the Fiscal Year covering the topics of:		
Substance Use/Abuse (including smoking)		
Family Violence (including intimate partner abuse)		
Mental Health Issues (e.g. symptoms of maternal depression)		
Others, please list. (Attach additional pages as necessary)		

Attachment G

Department of Human Services' Form A, B, & C

DHS FORM A - PEOPLE TO BE SERVED

ORGANIZATION: _____

PROGRAM/SERVICE: ***DHS Enhanced Healthy Start Services***

SITE(S): _____

PEOPLE TO BE SERVED	*ANNUALLY*
1. # of families receiving CWS Diversion Services with a child referred at 0-90 days of age	
2. # of families receiving CWS Diversion Services with a child referred at 91 days to one year of age	
3. # of families receiving CWS services with a child referred at 0-90 days of age	
4. # of families receiving CWS services with a child referred at 91 days to one year of age	

DHS FORM B – SERVICE ACTIVITIES

ORGANIZATION: _____

PROGRAM/SERVICE: ***DHS Enhanced Healthy Start Services***

SITE(S): _____

SERVICE ACTIVITIES	*ANNUALLY*
1. # of assessments completed within seven days of referral.	
2. # of individualized service plans developed within and agreed to by families within 45 days of referral for home visiting.	
3. # of families assisted to access referrals to community resources for:	
a. substance abuse	
b. domestic violence/intimate partner abuse	
c. mental health/maternal depression	
d. health problems	
e. early intervention services	
f. family planning	
g. other (please list)	

DHS FORM C - OUTCOMES

ORGANIZATION: _____

PROGRAM/SERVICE: ***DHS Enhanced Healthy Start Services***

SITE(S): _____

OUTCOMES	*ANNUALLY*
1. % of families that have no new report of abuse/neglect during the time of Enhanced Healthy Start Services.	90%
2. % of families that have no new confirmed report of abuse/neglect during the time of Enhanced Healthy Start Services.	99%
3. % of families that have no new report of abuse/neglect six months after case closure by Healthy Start and CWS or CWS Diversion services.	95%
4. % of families meeting targets set by basic Healthy Start services that are possible to accomplish within the 10-month period.	95%
5. % of families with reduced risk factors measured at six months as compared to the initial measurement.	90%
6. % of families expressing satisfaction with Enhanced Healthy Start Services.	90%
7. % of families meeting targets set by basic Healthy Start services.	95%

Attachment H

Clinical Specialist Model

According to the contract, the Clinical Specialist (CSp) shall provide short-term clinical services, not to exceed three (3) months. The focus on short-term service will be to work with families so that they will seek long-term treatment in the ***primary*** areas of:

- ***Family violence (including intimate partner abuse)***
- ***Substance use/abuse (including smoking)***
- ***Mental health issues (e.g., symptoms of maternal depression)***

A. Primary (mandatory) Referral Sources – referral to CSp occurs within 2 working days

1. Family Stress Checklist (FSC) – THE ASSESSMENT information from EID to HV IS REVIEWED BY THE CLINICAL SUPERVISOR UPON CASE ASSIGNMENT, FOR possible referral TO THE CLINICAL SPECIALIST (with possible coordination with Child Development Specialist].

{Red flags}

a. EID score over 50 *and/or*
b. #1 - Childhood History score is 10 [*potential* for family violence/ child maltreatment]
c. #2- Lifestyle Behaviors and Mental Health score is 10 [*chronic* substance use/abuse or *history* of mental health issues]
d. #6- Anger Management Skills score is 10 [*potential* for family violence / child maltreatment]
e. #10 Bonding and Attachment score is 10 [*possible* mental health issues]

2. At anytime during HV services when issues within the 3 primary areas of concern are current AND/OR known to FSW or Clinical Supervisor. Clinical Supervisor makes an immediate referral AT THIS POINT.

B. CSp Service Options (after a referral is received) where goal is to refer to a private provider:

1st ***Assess referral and associated risk. [If very complicated and high-risk in nature, refer out immediately].***
2nd ***Identify possible referral sources and establish preliminary care plan/service option in psychosocial assessment.***
3rd ***Assess readiness to change potential.***
4th ***Consultation with CS/FSW and CDS, as appropriate.***

a. Establish potential referrals to private provider within two weeks of CSp referral. Referral to private providers should be ongoing.

b. Creative outreach by inviting parent to a group activity.
c. Casual observation of parent during group activities.
d. Creative outreach through the FSW – suggestions to enhance engagement or acceptance of a private provider referral.
e. Consultation only for CS/FSW, including information given to give to family (handouts, referral information, clinical feedback).
f. Friendly visit as a team member.
g. Visit specifically to discuss a referral to private provider.
h. Home visits with the FSW to observe concerns/support parent with issues.
i. Engagement and assessment/PSI pre given. At the time of engagement the 3 month service period begins.
j. 3-month treatment readiness service (treatment is focused on getting family to see the need for and then accept referral for treatment from an outside professional or appropriate community treatment program/provider].
k. 3 month short term clinical services - No other services are available or family is unable to access the services. PSI post given at end of 3 month service to document reduction in parental stress.
l. Crisis Work – Assessment of suicidal risk, mental health crisis, and referral to outside agency/provider
m. Re-engagement due to crisis.
n. Aftercare and support – no more than once a month for a maximum of three months to provide support for family to continue services or maintain stability.
o. Caseload full – waitlisted.

C. Necessary Documentation and Forms for CSp service options:

CSp Referral Form*:*

- ***Reason for referral***
- ***Source of referral***
- ***Date of referral***
- ***Date referral received***

Pyschosocial Assessment Form*:*

- ***Specific EID information utilized***
- ***Referral Assessment***
- ***Risk Assessment***
- ***Readiness to Change Assessment***
- ***Identified Referral Sources***

- ***Services option(s) determined [may be more than one]***
- ***Date Psychosocial Assessment completed by the CSp (should not take longer than 3 working days]***
- ***Date of consultation with CS/FSW and/or CDS and outcome, including care strategies with implementation timelines.***

CSp Log (Contact) Sheet:

- ***After receipt of referral, include dated descriptions of all provided activities and services in chronological order on the CSp Log Sheet utilizing MCBH contract definitions.***
- ***State on the narrative portion of the CSp Log Sheet, the CSp observations/assessment of the developmental concerns in a logical format and include all tools/information that were utilized or reviewed. Document use of a variety of assessment and measurement tools.***
- ***Describe specific strategies planned and utilized for parents declining CSp services and/or referrals to private providers.***
- ***Describe intervention strategies provided or recommended for the parent and FSW. Include assessments used to monitor impact of intervention strategies employed.***
- ***Describe how strategies utilized with parents and/or FSW are impacting parent issues/concerns.***

IFSP:

- ***Provide IFSP developmental goals for the parent with issues/concerns and for confirmed diagnoses (for those declining CSp services or not participating in private providers services).***

PSI:

- ***Pre and post on all engaged clients.***

Discharge Form:

- ***Pre and post to measure the progress of the client.***
- ***Summary of progress at discharge.***
- ***Referrals accepted.***

On-going Monitoring:

- ***Dates and impact of aftercare and support provided.***
- ***Engagement with outside agency/provider services.***

Best Practice

1. ***Clinical Supervisor completes CSp Referral Form within 2 working days and forwards directly to CSp.*** *The Clinical Supervisor is seen as the case manager - all referrals and activities of the CSp are shared and agreed upon with the Clinical Supervisor.*

2. *Each family that is referred for services will have a completed Referral Form and the EID assessment reviewed by the CSp. Information that is needed to assess level of risk will be obtained during a consultation with FSW and Clinical Supervisor.*

3. *CSp must use "Readiness to Change" and current Risk Factors/Strengths to determine openness to/acceptance of services. If the family is not open to or accepting services, the CSp will discharge the case from active caseload and continue consulting with the Clinical Supervisor and/or FSW to address/follow-up on areas of concern. Documentation of possible Service Options considered will be noted on a Client Service Log.*

4. *Families are referred to community services outside of Healthy Start whenever possible. The CSp obtains consent to assist with the referral process and tracks the type of referral and outcome. (See CSp Quarterly Report for more detailed info.)*

5. *Continuing documentation on the CSp log/narrative should provide information on the best* "Service Option" *available for the referral and all contacts/consultations/visits made on behalf of this case must be documented on a Client Service Log (See the Clinical Specialist Quarterly Report for further information on contract requirements/objectives.)*

6. *If the CSp engages family in services the decided upon goals should be written into the IFSP and be within the 3 month services limit.*

7. *A complete* Psychosocial Assessment *will be conducted with those engaged in clinical services or treatment readiness services.*

8. *CSp will develop and implement a care plan that will be used to facilitate/coordinate with the Clinical Supervisor and FSW during the 3 months of treatment readiness services. The care plan will be part of the IFSP and the goals documented on the IFSP.*

9. *The CSp will use a variety of assessment and measurement tools (once the family engages in CSp services) to evaluate the symptoms and measure the progress of the client –pre and post. The MCHB identified tool is the PSI (Parental Stress Index). [See Protocol for the*

PSI for further information.] All contacts with the family and consultations must be documented on a Client Service Log

10. *In the event that the 3-month service period is inadequate to complete the goals or a new crisis arises, the Clinical Specialist will submit an Exception Form to the Healthy Start Program Head – signed by the Supervisor of the CSp documenting the reasons for the exception and the plan for extended treatment, including anticipated timeline of 3 months. This must be done before the 3-month service period is completed.*

Phases of Service

A. *Pre-engagement Period*

If CSp assessment of "Readiness to Change" and current Risk Factors/Strengths indicates that the family is open to or accepting services, the CSp will engage in a variety of creative outreach efforts to engage the family in services and agree to a Family Service Plan for a period not to exceed three months.

If CSp assessment of "Readiness to Change" and current Risk Factors/Strengths indicates that the family is not open to or accepting services, the CSp will discharge family and will continue to provide consultation to the FSW, as needed.

B. *Engagement Period*

There is 3-month "Treatment Readiness" and "Clinical Services period" that begins when the family agrees to services and a measurable Family Service Plan is created, signed and services noted on the IFSP service summary form. A psychosocial assessment and a pre-intervention (PSI) is completed as soon as possible.

C. *Discharge Period*

After the completion of the 3-month "Treatment Readiness" and "Clinical Services period" (or any time the family disengages from treatment readiness services prior to the 3-month timeframe) the CSp will discharge family. Documentation will include summary of progress, post-assessment, documentation of referral and/or resources shared, and a post-intervention {PSI}.

D. *Aftercare/Support*

Families can be serviced no more than once a month for a maximum of three months to ensure that outside private provider treatment services are consistently utilized and to assess the stability and integration of recommended family interventions.

Exceptions

If professional or appropriate treatment services are not available (and documented) and temporary services will be provided then the 3-month "Exception Form" should be requested. Exceptions for extension of services may be granted by request and supervisor recommendation through MCHB. Exceptions should be requested as soon as it becomes apparent that the 3 month period will not be adequate to complete the Family Service Plan goals, instead of waiting until the end of the period. Exceptions will be limited to a maximum *of two per family per incident.*

Necessary CSp Documentation and Forms

1. *Referral form*
2. *Log Sheet [contacts & narrative]*
3. *Care Plan (IFSP attachment]*
4. *Psychosocial Assessment*
5. *Pre and post PSI on engaged clients*
6. *Discharge Form*
7. *3 month Exception Form*
8. *On-going Monitoring Form*
9. *CSp quarterly report on MCHB approved form.*
10. *CSp annual report on MCHB approved form*

Case Management Supervision

Case management is weekly by the Clinical Supervisor or other appointed supervisor as determined by the Program Director.

Clinical Supervision

As stated in the contract, persons qualified for the Clinical Specialist position should possess a Master's in Clinical Social Work, Clinical Psychology, Counseling or equivalent degree in related health or human service field with a minimum of 3 years of experience in a clinical setting. Professionals meeting these qualifications providing treatment readiness services should not require clinical supervision.

If professional or appropriate treatment services are not available and the CSp is providing service, then the CSp may require clinical supervision for service of a very complicated and/or high-risk nature. As determined by the Program Director, an outside Clinician may be utilized if there is no professionally appropriate staff person within the agency. Subcontracting must have prior DOH approval.

Other responsibilities

- *CSp will attend meetings/trainings as required by MCHB, Supervisor, or Program Director.*
- *CSp should conduct groups and participate as part of a "training team" at Parent Support Groups within each Healthy Start site.*
- *CSp conducts a minimum of one training per quarter for families and staff, as determined by needs and contract requirements.*

Table III. HHS CSp Logic Model

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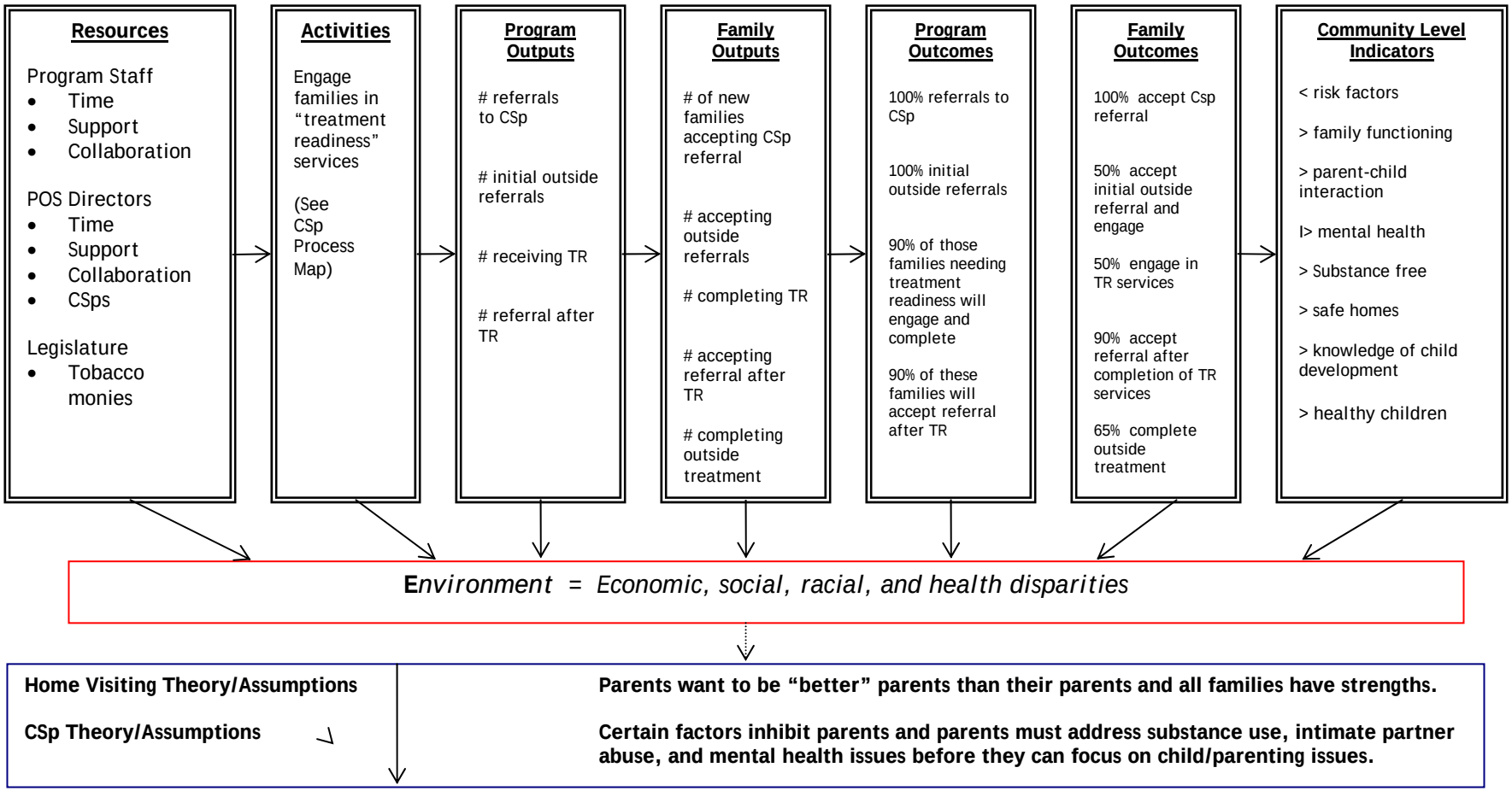
Participants: Overstressed families [first time parents, mother primary caregiver, 21-29 years, part-Hawaiian, not married, H.S. educated, full or partial DHS} with a newborn at high risk for CAN due to history and/current impact of intimate partner abuse, substance use, mental health issues (including maternal depression).



Baseline Data 2001-02 *CTS* [38% showed co-morbidity on all 3]	56%	42%	31%	** as reported from FSC via*
2002-03 Data *Standard – 100% CSp referral for*	**Sub Abuse**	**I P Abuse**	**Maternal Depression**	**{Per Qtr.}**
50% accept initial outside referrals	36%	24%	42%	
50% receiving TR	28%	38%	40%	
90% accepting referral after TR	67%	52%	70%	

Table IV.

A. New Family Outcomes	New Family Indicators – As indicated by CSp Record and Quarterly Reports
1. Acceptance of CSp referral	100% of "at-risk" families (FSC > 50) and/or current substance use, intimate partner abuse, mental health issues will accept referral to the CSp within the three month "engagement period" **[n = 200 per mo.]**
2. Acceptance of outside referral	"At-risk" families will accept referral to outside professional services within one month of referral: a. 50% initially (before "treatment readiness" services) [n = 100] b. 40% after "treatment readiness" services [n = 80}
3. Engagement in "treatment readiness" services	90% of CSp referred families will engage in three-month / 12 session "treatment readiness" services [n = 90]
4. Completion of services	"At-risk families will complete service a. 75% will complete "treatment readiness" services [n = 75] b. 75% will complete outside professional services [n = 75]
B. Program Outcomes	**Program Indicators – As indicted by the Family Progress Record and Discharge Summaries**
1. CSp referral	100% of "at-risk" families (FSC > 50) and/or current substance use, intimate partner abuse, mental health issues will be referred to the CSp within 48 hours of program admission or awareness of current situation [n = 200]
2. Outside referral	100% of "at-risk" families will be referred to outside professional services on an on-going basis until acceptance of referral or program discharge [n = 200]
3. "Treatment readiness" services	90% of "at-risk" families declining initial outside professional referral will engage in three-month / 12 session "treatment readiness" services [n = 90]
4. Completion of services	75% of "at-risk" families will complete "treatment readiness" services [n = 75]
C. Community Outcomes	**Community Indicators – As indicted by families remaining the home visiting program until the target child reaches age three years and successfully completing services**
1. Reduce risk\stress factors	00% of CSp served families will reduce their risk factors in a pre- and post-comparison of scores from the Family Stress Checklist (FSC) on #4, #5, #6, and #8, the Parental Stress Index (PSI), and the Risk Protocol [n = 200]
2. Improve mental health	75% of CSp served families indicate improved mental health as documented in the Family Progress Record, CSp Record, Clinical Supervisor notes, IFSP, and Child Welfare Service (CWS) referral
3. Substance free families	75% of CSp served families will be substance free as documented in the Family Progress Record, CSp Record, Clinical Supervisor notes, IFSP, and Child Welfare Service (CWS) referral [n = 150]
4. Families in a safe, non-violent home	75% of CSp served families will live in a safe, non-violent home as documented in the Safe Home Checklist, Family Progress Record, CSp Record, Clinical Supervisor notes, IFSP, and Child Welfare Service (CWS) referral
5. Increase family functioning	100% of CSp served families demonstrate increased family functioning as documented in the IFSP, home visiting summary and Level movement in the Family Progress Record and Clinical Supervisor notes
6. Enhance parent-child interaction	100% of CSp served families demonstrate enhanced parent-child interaction as documented in the IFSP, home visiting summary and Level movement in the Family Progress Record and Clinical Supervisor notes, and
7. Better understanding of child development	100% of CSp served families demonstrate better understanding of child development as documented in IFSP and the Child Observation Checklist.
8. Safe, happy, healthy children	100% of CSp served families' child(ren) will be current on immunizations and well-baby check-ups as verified in the HV record, and improved scores on the NCAST HOME and TEACH screens

Primary Secondary

Attachment I

Child Development Specialist Model

Maternal and Child Health Branch (MCHB)
Child Development Specialist (CDS) MODEL

The contracted responsibility of the CDS is to conduct, monitor, and evaluate referred target children utilizing developmental screening tools to support optimal growth and development via group activities and individual consultations utilizing a variety of appropriate and timely intervention strategies. A key role is to provide timely referrals to Early Intervention Section (EIS) with appropriate follow-up. Technical assistance and trainings are also provided to Family Support Workers (FSW) and Clinical Supervisors (CS) to ensure developmental tools and activities are utilized appropriately. MCHB program monitoring will be based on implementation of this model as will program quality improvement plans.

A. Primary (mandatory) Referral Sources

1. ***Mandatory Contract Requirements – referral to CDS occurs within 5 working days***
   - 1 Standard Deviation (SD) in one developmental domain consecutively from one assessment period to the next SD in Gross Motor at 4 mos. and again at 6 mos.) on the Ages and Stages Questionnaire (ASQ)
   - 1 SD in more than 1 developmental domain on the ASQ
   - 2 SD in any developmental domain on the ASQ
   - Ages and Stages Questionnaire – Social Emotional (ASQ-SE) with score above cut-off

2. ***Parent/Child Interaction (PCI) Screens – referral to CDS occurs within 5 working days***

   - 6 month Nursing child Assessment Satelitte Training (NCAST) Teach score below 44
   - 18 month NCAST Teach score below 46
   - NCAST Feed done at 1-5 months (Optional) score below 49
   - NCAST Feed done at 6-12 months (Optional) score below 54
   - HOME at 4-8 months score below 32

3. FSW, CS, or parent concern on child development issues – referral to CDS occurs within five working days.

B. Secondary (optional as determined by each individual program and coordinated with Clinical Specialist) Referral Sources [Red flags – potential for CAN] with Early Identification (EID) score of 10 on:

a. #1 – Childhood Experience
b. #3 – Parenting Experience
c. #7 – Expectations of infant's developmental milestones and behavior
d. #8 – Plans for discipline
e. #9 – Perception of new infant
f. #10 – Bonding and Attachment

Maternal and Child Health Branch (MCHB)
Child Development Specialist (CDS) MODEL

C. CDS service options (after a referral is received):

a. Referral to EIS or private provider within two weeks of referral to the CDS.
b. Creative outreach for parental acceptance of EIS referral including intervention activities and role-modeling at a home visit.
c. Referral to the pediatrician within two weeks of referral to the CDS.
d. Engagement and assessment of child with Hawaii Developmental Chart (HDC) or other screening tool.
e. Intervention activities and role-modeling at home visits for parents declining EIS services.
f. Advising the FSW/CS on intervention activities and role-modeling at FSW home visits for parents of children with confirmed developmental delays.
g. Supportive home visits especially when EIS appointments are not being kept.
h. Home visits with the FSW to observe a child with questionable screening results.
i. Casual observation of child during parent support group meetings.
j. Consultation only for parent or FSW.
k. Care coordination (if CDS is most appropriate person).
l. Provide technical assistance to the FSW in supporting the interventions described on the Individual Family Support Plan (IFSP).

D. Documentation of provided CDS service options:

a. Include the reason for, source of, and date of referral to the CDS.
b. Include the services option(s) determined and date determined by the CDS.
c. After receipt of referral, include dated descriptions of all provided activities and services in chronological order on the CDS file.
d. State on the narrative portion of the CDS file, the CDS observations/assessment of the developmental concerns in a logical format and include all tools/information that were utilized or reviewed.
e. Indicate if and how specific EID information was utilized as part of the child development assessment.
f. Describe strategies planned and utilized for parents declining EIS services.
g. Describe intervention strategies provided or recommended for the child and FSW. Include assessments used to monitor impact of intervention strategies employed.
h. Describe how strategies utilized with parents and/or FSW are impacting target child's development.
i. Provide IFSP developmental goals and intervention strategies for the child with suspected developmental delays and for confirmed developmental delays (for those declining EIS services or not enrolling in EIS services).

E. Clinical and Case Management Supervision of the CDS can be provided by:

a. The Program Clinical Supervisor, or

b. Other qualified professional as determined by Program Director (qualifications must be documented and meet contract requirements).

F. Other responsibilities of the CDS:

a. Demonstrate child development activities for families and/or staff.
b. Conduct trainings for families and staff in child development issues and/or various developmental screening tools.
c. Attend MCHB meetings, as requested.
d. Act as care coordinator or liaison for target child with confirmed developmental delays at a family's request and after family has been informed of most appropriate options.

Best Practice

1. Referrals to the CDS will be done in a timely manner. To meet Felix vs. Lingle Consent Decree guidelines, any child that scores [A. 1.] 2SD in any developmental domain OR 1SD on more than one developmental domain OR 1SD in one developmental domain consecutively from one assessment period to the next (1SD in Gross Motor at 4 mos. and again at 6mos.) on the ASQ OR that scores above the cut-off on the ASQ-SE OR [A. 2.] any scores below the cut-off on PCI Screens will be referred to the CDS ***within five working days***. All other referrals will be forwarded to the CDS within five working days from initial concerns noted

2. Each referred family will have a completed CDS Referral Form that indicates date referral was made, date referral was received and date CDS contacted the family. [EID information can be used as supplemental information to assist the CDS in making pre-assessment plans.]

3. The CDS Quarterly Report will be utilized to account for all activities done by the CDS.

4. CDS documentation will be on a different form from the home visitors documentation. A CDS section within the family record is recommended.

5. The CDS referral process for outside professional evaluation for suspected developmental delay will occur ***within 2 weeks*** from the date of CDS referral. Preferably, the home visitor will inform the supervisor during weekly supervision and the supervisor will immediately make a referral to the CDS. For a 2SD score on the ASQ the home visitor will alert their supervisor as soon as possible.

6. The CDS findings will be based on the results of all developmental screening tools and supporting information used in completing the assessment of the child's developmental skills.

7. The CDS will recommend the next step to be taken, and by whom, in supporting the child in meeting developmental goals where there is a suspected delay.

8. The program must have a process in place that ensures care coordination is being provided after CDS referral to an EIS agency or private provider for professional evaluation(s). Families will be educated as to the most appropriate care coordinator. Documentation on the child's IFSP will state the designated care coordinator and the steps being taken.

9. The CDS will provide intervention strategies for the home visitor to utilize during home visits to support the child in meeting developmental goals. The CDS will also provide technical assistance to the home visitor when an EIS agency recommends intervention strategies for the child and the CDS expertise is needed. It is important to demonstrate the success of any interventions.

10. The creative outreach activities for the CDS intervention will consist of child developmental activities provided through home visits, the FSW, or in a supportive group setting.

Attachment J

Form C-3

Performance –Based Budget

PERFORMANCE-BASED BUDGET
(SUMMARY SHEET)

RFP # HTH 550-3

Applicant/Provider _____

Modality/Unit of service to be provided	Fiscal Year 2006	Fiscal Year 2007	Fiscal Year 2008	Fiscal Year 2009

Note:

Applicants must complete the Performance-Based Budget Backup Worksheets for each fiscal year.

Prepared by: **Phone No.**
Date:

Signature of Authorized Official: **Phone No.**

Name & Title (Please Print or Type): **Date:**

PERFORMANCE-BASED BUDGET
(BACKUP WORKSHEET)
FISCAL YEAR 2006

Applicant/Provider _____

(a)	(b)	(c)	(d)	(e)	(f)
Modality/Unit of service to be Provided	**Number of Clients to be Served**	**Frequency (Estimated Number of [1]Service Units per Client per Fiscal Year)**	**[2] Total Service Units (b x c)**	**Unit Cost**	**Total FY 2006 (d x e)**
TOTAL					

[1] A service unit is defined as the quantitative measurement of the service being purchased. This quantitative measure could be in units of time, e.g., bed-day or a counseling hour, or in units of tangible services. For early identification services, the service unit is defined as screen/assessment hour.

[2] Total service units should be based on a reasonable annual operating capacity for the program. Operating capacity is defined as adequate, planned and budgeted space, equipment and staff.

PERFORMANCE-BASED BUDGET
(BACKUP WORKSHEET)
FISCAL YEAR 2007

RFP # HTH 550-3

Applicant/Provider _____

(a)	(b)	(c)	(d)	(e)	(f)
Modality/Unit of service to be Provided	**Number of Clients to be Served**	**Frequency (Estimated Number of [1]Service Units per Client per Fiscal Year)**	**[2] Total Service Units (b x c)**	**Unit Cost**	**Total FY 2007 (d x e)**
TOTAL					

[1] A service unit is defined as the quantitative measurement of the service being purchased. This quantitative measure could be in units of time, e.g., bed-day or a counseling hour, or in units of tangible services. For early identification services, the service unit is defined as screen/assessment hour.

[2] Total service units should be based on a reasonable annual operating capacity for the program. Operating capacity is defined as adequate, planned and budgeted space, equipment and staff.

PERFORMANCE-BASED BUDGET
(BACKUP WORKSHEET)
FISCAL YEAR 2008

RFP # HTH 550-3

Applicant/Provider _____

(a)	(b)	(c)	(d)	(e)	(f)
Modality/Unit of service to be Provided	**Number of Clients to be Served**	**Frequency (Estimated Number of [1]Service Units per Client per Fiscal Year)**	**[2] Total Service Units (b x c)**	**Unit Cost**	**Total FY 2008 (d x e)**
TOTAL					

[1] A service unit is defined as the quantitative measurement of the service being purchased. This quantitative measure could be in units of time, e.g., bed-day or a counseling hour, or in units of tangible services. For early identification services, the service unit is defined as screen/assessment hour.

[2] Total service units should be based on a reasonable annual operating capacity for the program. Operating capacity is defined as adequate, planned and budgeted space, equipment and staff.

PERFORMANCE-BASED BUDGET
(BACKUP WORKSHEET)
FISCAL YEAR 2009

RFP # HTH 550-3

Applicant/Provider _____

(a)	(b)	(c)	(d)	(e)	(f)
Modality/Unit of service to be Provided	**Number of Clients to be Served**	**Frequency (Estimated Number of [1]Service Units per Client per Fiscal Year)**	**[2] Total Service Units (b x c)**	**Unit Cost**	**Total FY 2009 (d x e)**
TOTAL					

[1] A service unit is defined as the quantitative measurement of the service being purchased. This quantitative measure could be in units of time, e.g., bed-day or a counseling hour, or in units of tangible services. For early identification services, the service unit is defined as screen/assessment hour.

[2] Total service units should be based on a reasonable annual operating capacity for the program. Operating capacity is defined as adequate, planned and budgeted space, equipment and staff.

Attachment K

Department of Health's Directive Number 04-01 dated May 3, 2004

LINDA LINGLE
GOVERNOR OF HAWAII

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

INTRA-DEPARTMENTAL DIRECTIVE 04-01
May 3, 2004 Page 1 of 5

TO: All Deputies, Division and Branch Chiefs, Staff Officers, District Health Officers, and Administrators of Attached Agencies

FROM: Chiyome Leinaala Fukino, M.D.
Director of Health

SUBJECT: ***INTERPERSONAL RELATIONSHIPS BETWEEN STAFF AND CLIENTS/PATIENTS***

04-1.1 **PURPOSE**

This directive provides the policy for the State of Hawaii, Department of Health on interpersonal relationships between staff and clients/patients.

04-1.2 **POLICY**

A. Staff shall not use their professional position to exploit others for any reason.

B. Staff shall avoid engaging in dual/multiple relationships with clients/patients or former clients/patients. When dual/multiple relationships are unavoidable, staff shall take steps ensure that the nature of the dual/multiple relationship shall neither harm nor exploit the client/patient.

C. Sexual relationships with any client/patient or former client/patient are prohibited. Staff shall not have financial relationships with clients/patients or former clients/patients.

D. Staff are prohibited from engaging in sexual relationships with clients/patients' relatives or other individuals with whom clients/patients maintain close personal relationships, or to whom clients/patients are reliant upon. Staff are required to set clear, appropriate and culturally sensitive boundaries.

E. Staff shall neither initiate, assume, nor maintain a treatment relationship to individuals with whom they have had prior sexual relationships. Staff shall inform their supervisor if there have been past relationships with potential clients/patients and arrange to have the care of such patients/clients provided by another qualified staff person.

F. Staff shall not engage in physical contact with clients/patients when there is a possibility of psychological harm to the clients/patients as a result of the contact (such as cradling or caressing clients/patients). In providing services, staff who are required to have physical contact with clients/patients are responsible for setting clear, appropriate and culturally sensitive boundaries that govern such physical contact.

G. Staff who anticipate the potential for sexual relationships with former clients/patients shall consult in depth with their supervisors, exploring the various risks and concerns.

04-1.3 SCOPE

This directive applies to all Department of Health employees, including volunteers, who provide treatment and/or services and individuals or agencies that are contracted to provide treatment and/or services on behalf of the Department of Health.

04-1.4 DEFINITIONS

Clients/Patients:	Persons under observation, care, treatment, or receiving services.
Department:	Department of Health
Director:	Director of Health

Dual/multiple relationships:	When an employee has, or has had, more than one relationship with a patient or client, either presently or in the past. These may include professional, business, social, or personal relationships. Dual/multiple relationships can occur simultaneously or consecutively.
Staff:	Department employees, including volunteers, and individuals or agencies that are contracted to provide services on behalf of the Department.
Health:	Includes physical and mental health.
Providers:	Any persons, public or private vendors, agencies,or business concerns authorized by the department to provide health care, services, or activities.
Services:	Appropriate assistance provided to a person with a medical illness, developmental disability, mental illness, substance abuse or dependency disorder, or mental retardation. These services include, but are not restricted to assessment, case management, care coordination, treatment, training, vocational support, testing, day treatment, dental treatment, residential treatment, hospital treatment, developmental support, respite care, domestic assistance, attendant care, habilitation, rehabilitation, speech therapy, physical therapy, occupational therapy, nursing counseling, family therapy or counseling, interpretation, transportation, psychotherapy, and counseling to the person and/or to the person's family, guardian or other appropriate representative.
Treatment:	The broad range of services and care, including diagnostic valuation, medical, psychiatric, psychological, and social service care, vocational rehabilitation, career counseling, and other special services which may be extended to a person in need or with a disabling condition.

04-1.5 RESPONSIBILITIES

A. **Director**: Insure this policy is maintained, interpreted, updated, and communicated to all program managers.

B. **Deputy Directors**: Insure this policy is communicated to, understood and implemented by program managers within their administrations, and insure needed revisions of this policy are communicated to the Director.

C. **Program Managers**:

(1) Insure this policy is communicated to and understood by all vendors, providers, or contractors, and insert a reference to this policy in appropriate contracts.

(2) Insure this policy is enforced.

(3) Investigate alleged or reported infractions of this policy and take corrective actions as may be indicated.

(4) Recommend needed changes to this policy to their Deputy Directors.

D. **Employees**: Comply with this policy and report alleged infractions of this policy to their supervisors or superiors.

E. **Providers**: Insure this policy is communicated, understood, and implemented.

04-1.6 PROVISO

If there is a conflict between this policy and a collective bargaining agreement, the collective bargaining agreement shall prevail.

04-1.7 **REFERENCES**

A. Discrimination in Public Accommodations, Chapter 489, Hawaii Revised Statutes, as amended.

B. Fair treatment, Section 84-13, Hawaii Revised Statutes, as amended.

C. Rights of persons with developmental or mental retardation, Section 333F-8, Hawaii Revised Statutes, as amended.

D. Rights of recipients of mental health services, Chapter 334E, Hawaii Revised Statutes, as amended.

E. Sex Discrimination, Title 12, Chapter 46, Subchapter 4, Hawaii Administrative Rules, as amended.

F. Disability Discrimination, Chapter 46, Subchapter 9, Hawaii Administrative Rules.

This document should be placed in the Personnel Manual of Policies and Procedures under Section 11, SUBJECT: EMPLOYEE RELATIONS.